Appendix 1

NH Medicaid Care Management Public Forum Summaries

The purpose of these forums was to **provide the public with an opportunity to learn about the current proposed managed care approach** for Medicaid and for the **public to provide feedback and input** the department will use **in developing the RFP** for potential vendors

As part of the stakeholder engagement process, Louis Karno & Company and Pontifex Consulting facilitated **six public forum** events over the course of three weeks in **September 2011**. These forums were:

Keene – September 13
Nashua – September 14
North Country* – September 21
Somersworth – September 22
Manchester – September 23
Concord – September 29

*North Country was facilitated virtually from Littleton, with remote sites in Lebanon and Berlin

Please note that the comments and priorities that follow reflect the opinions of participating workgroups and not necessarily those of the Department of Health and Human Services.

Photos of charts reflect workgroup work process and product. Items crossed out typically reflect brainstormed suggestions that were combined with others.

NH Medicaid
Care Management Program
Public Forum

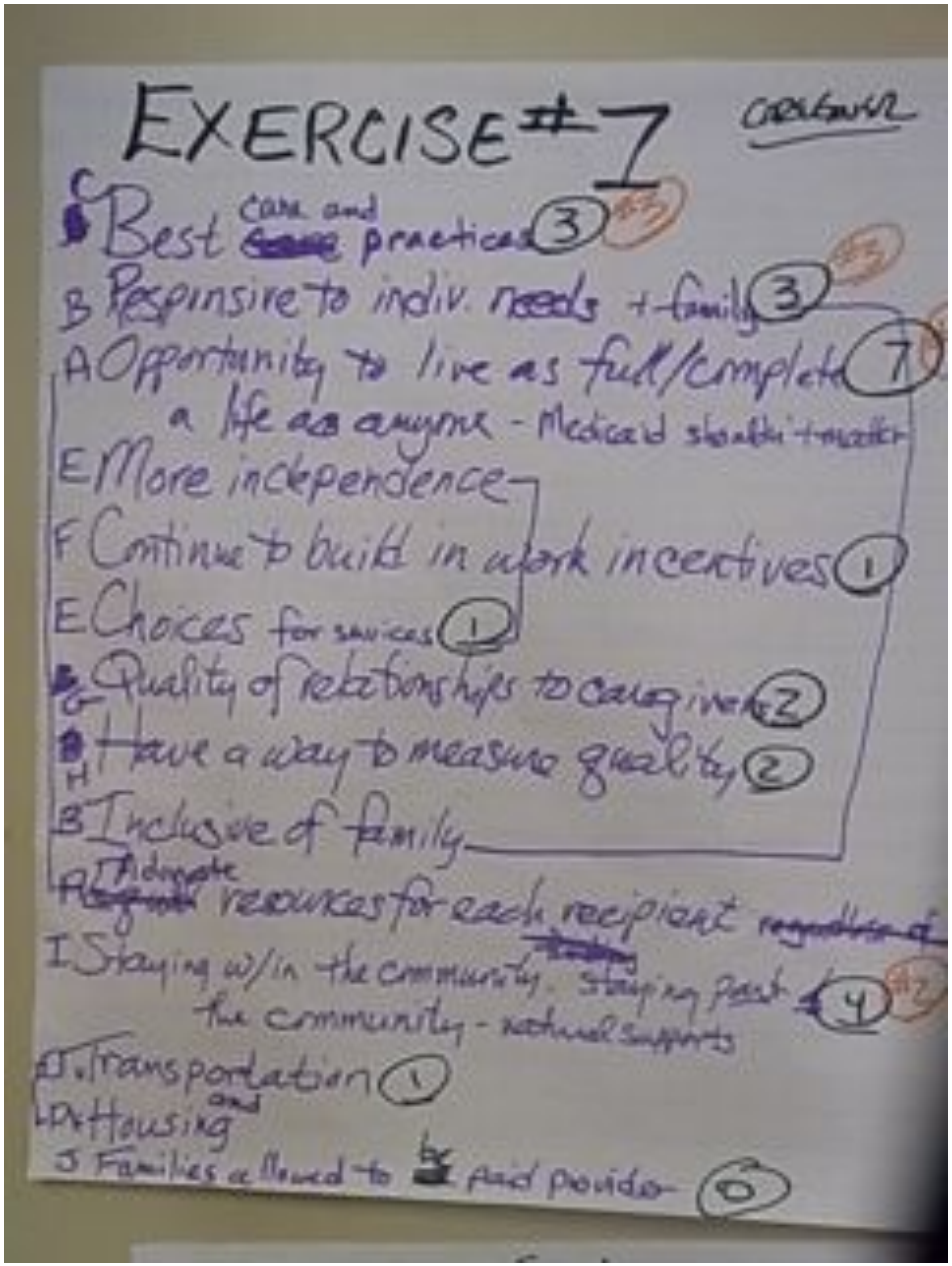
Keene, NH

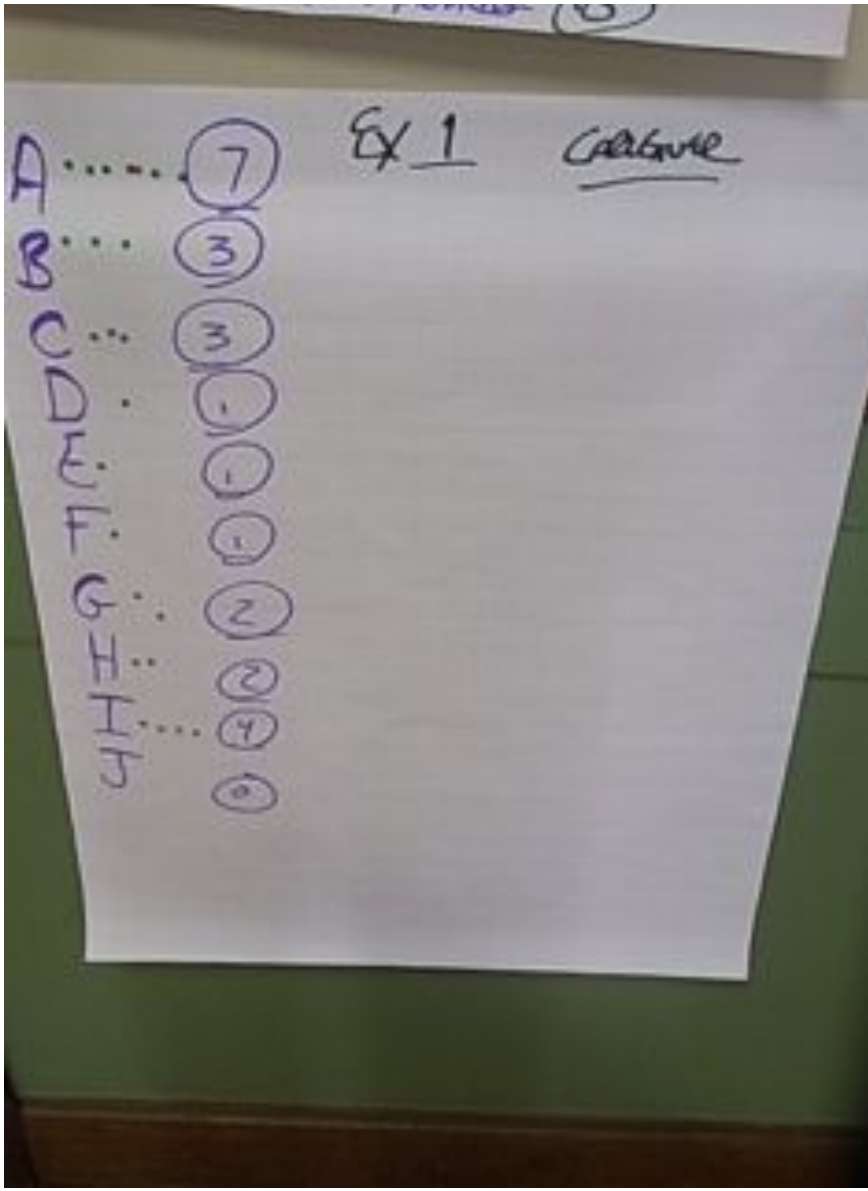
September 13, 2011

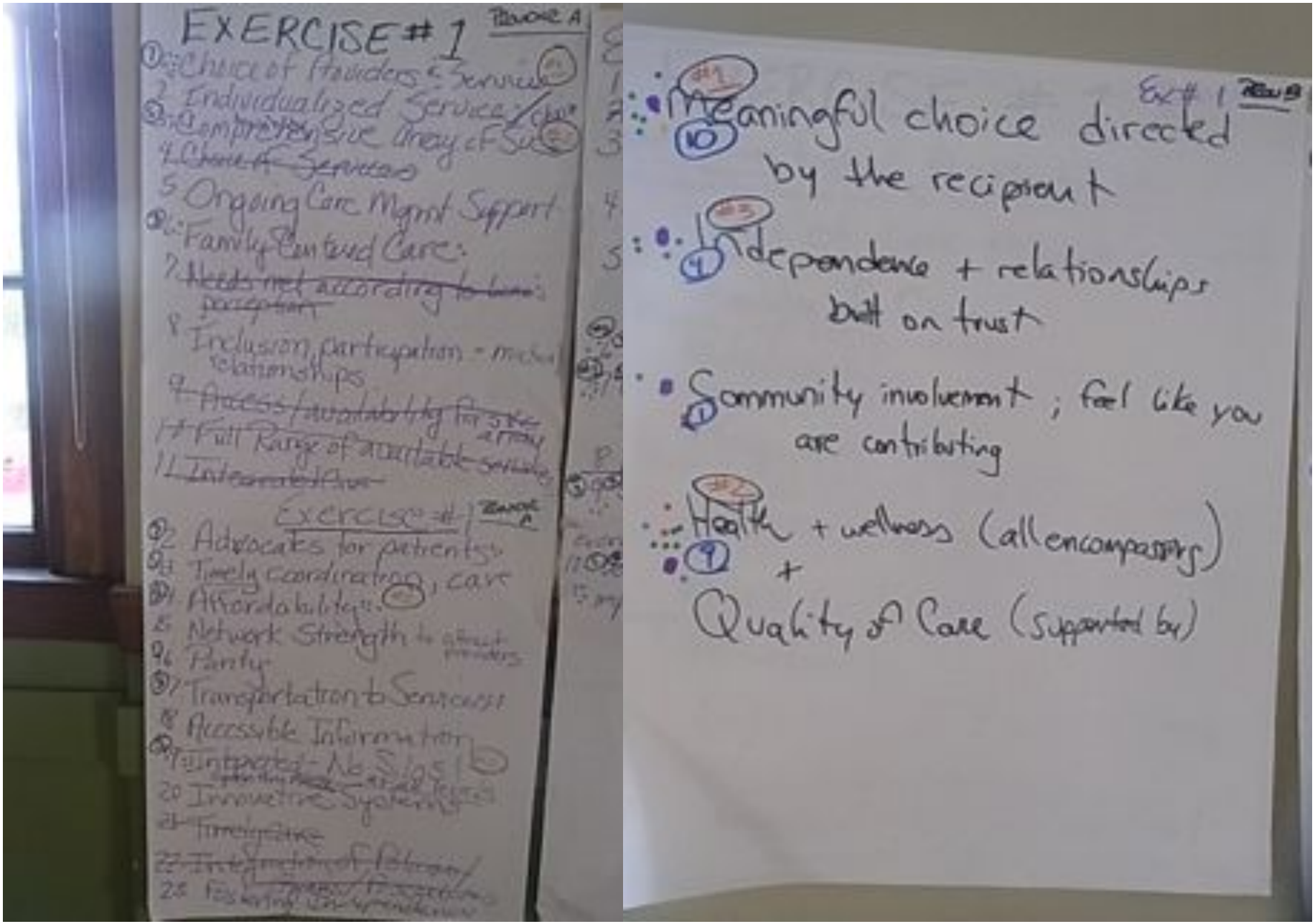
Recipient AND Provider Perspective – Exercise 1

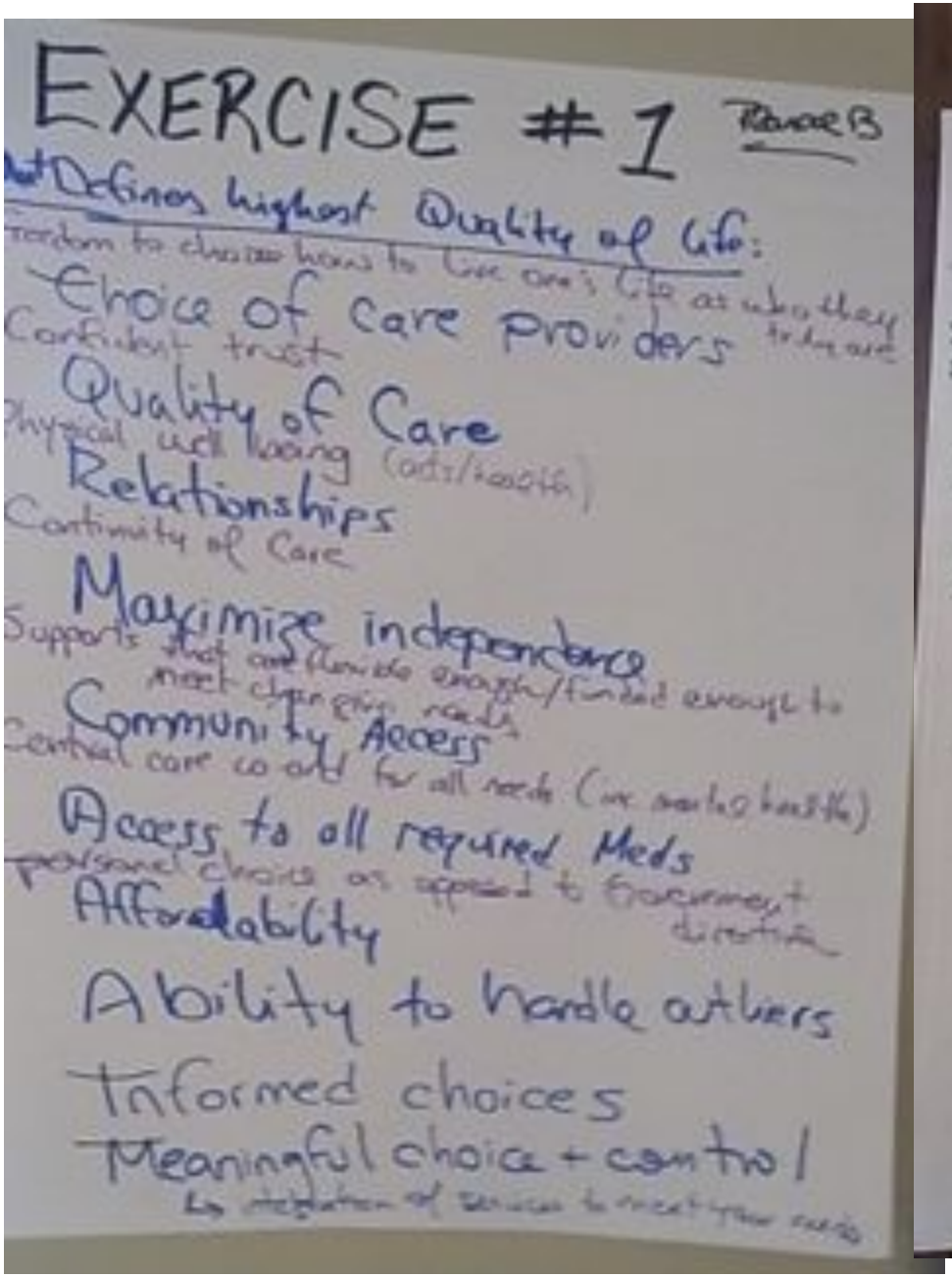
For someone receiving Medicaid, what defines having the highest quality life/health?

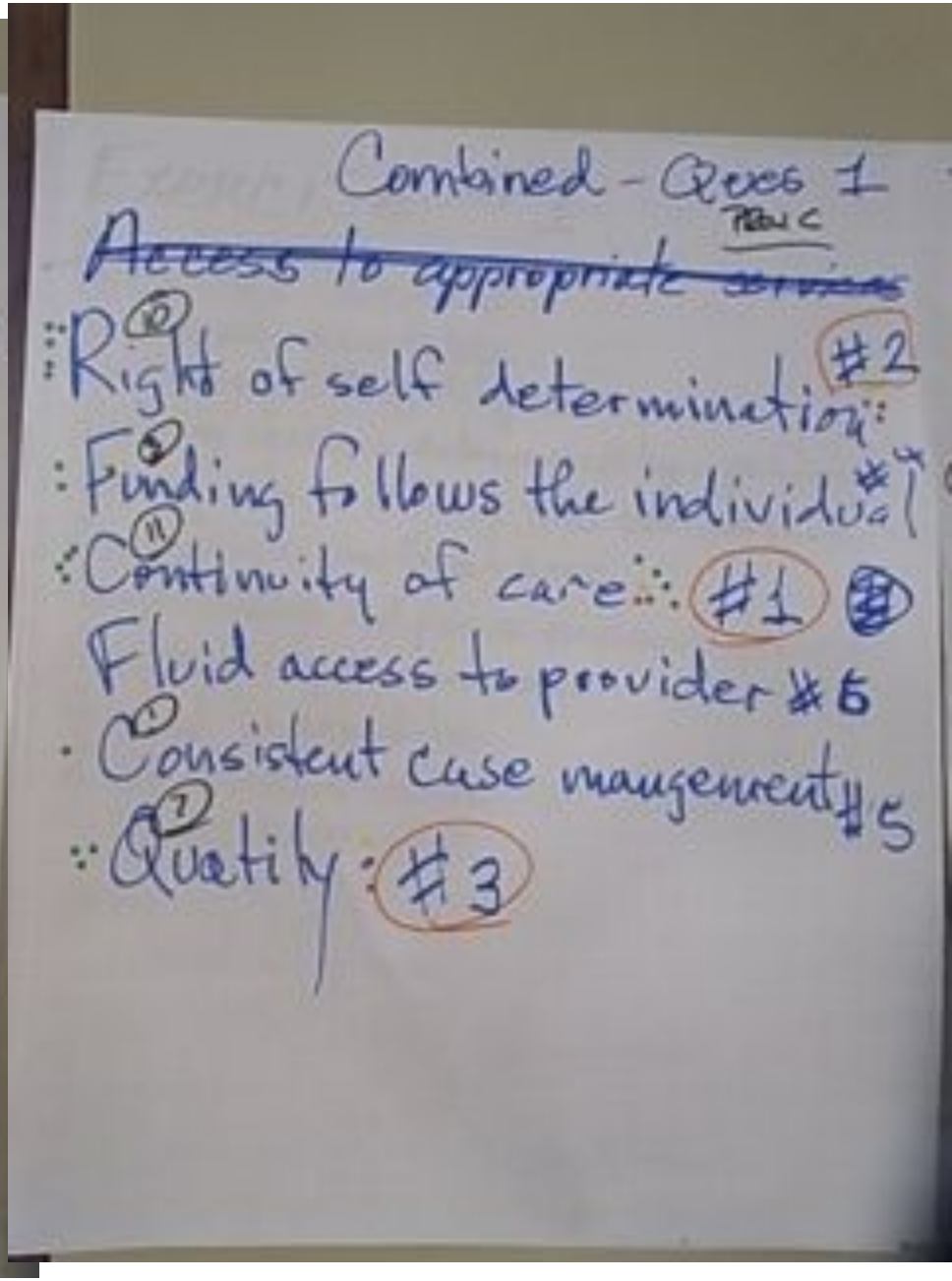
- Opportunity to live as fully as people not on Medicaid
- Resources for every recipient
- Choice or Providers and Services
- Availability of Comprehensive Array of Services
- Meaningful choice directed by recipient
- All encompassing health and wellness
- Independence and relationships built on trust
- Continuity and constancy of care…right care right time
- Self Determination
- Quality
- Affordability
- Intergration of Services at all Levels – Breaking Down of Silos at Federal, State, and Provider, and Individual Level


EXERCISE #7
C Best care and practices (3)
B Responsive to indiv. needs + family (3)
A Opportunity to live as full/complete a life as anyone - Medicaid should + matter (7)
E More independence
F Continue to build in work incentives (1)
E Choices for services (1)
G Quality of relationships to caregivers (2)
H Have a way to measure quality (2)
B Inclusive of family
A Adequate resources for each recipient
I Staying w/in the community. Staying part of the community - natural supports (4)
J Transportation (1)
A Housing
J Families allowed to be paid provider (0)


Ex 1
A ..... (7)
B ... (3)
C ... (3)
D . (1)
E . (1)
F . (1)
G . . (2)
H .. (2)
I .... (4)
J (0)


EXERCISE #1
Meaningful choice directed by the recipient
dependence + relationships built on trust
Community involvement; feel like you are contributing
Health + wellness (all encompassing)
+
Quality of Care (supported by)

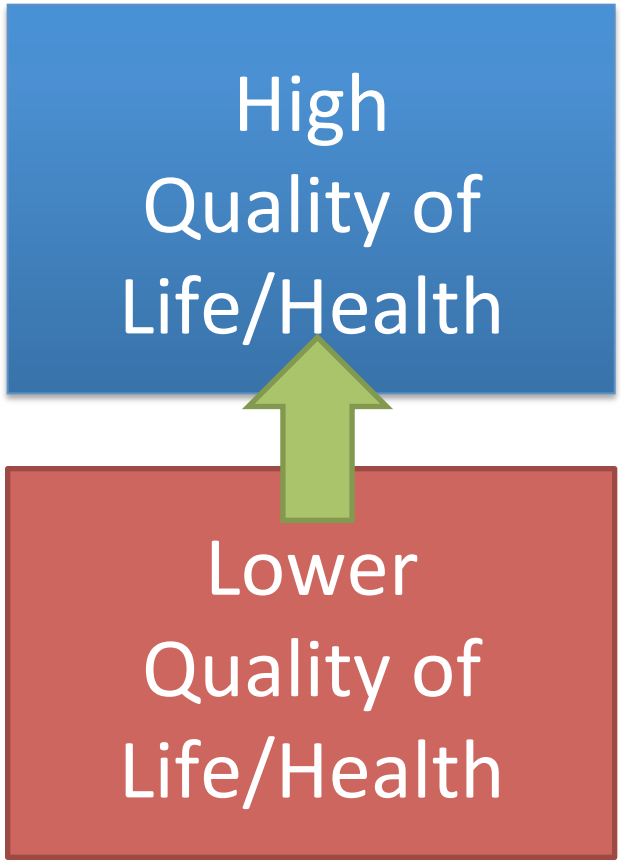

EXERCISE #1
Table B
Defines highest Quality of Life:
Freedom to choose how to live one's life as who they want to be and
Choice of care providers
Confident trust
Quality of Care
Physical well being (ADLs/health)
Relationships
Continuity of Care
Maximize independance
Supports that are flexible enough/funded enough to meet changing needs
Community Access
Central care to all for all needs (not medical health)
Access to all required Meds
Personal choice as opposed to Guardianship direction
Affordability
Ability to handle others
Informed choices
Meaningful choice + control
to adaptation of services to meet your needs

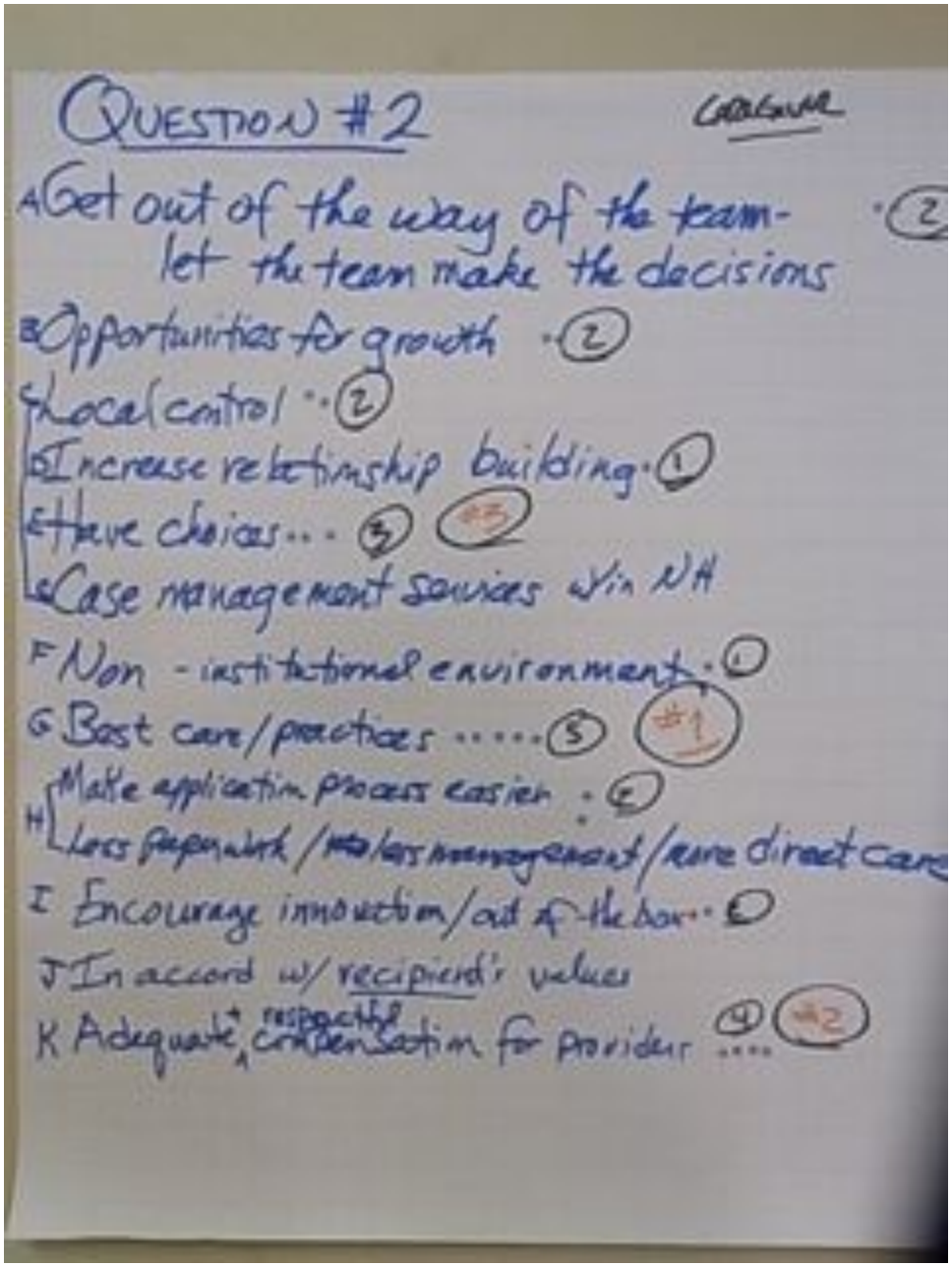

Contained - Exercise 1
Table C
Access to appropriate services
Right of self determination #2
Funding follows the individual #4
Continuity of care #1
Fluid access to provider #6
Consistent case management #5
Quality #3

Recipient Perspective - Exercise 2

What's needed to increase # with high quality of life/health?

- Using best practices.
- Adequate and respectful compensation for providers
- Choices

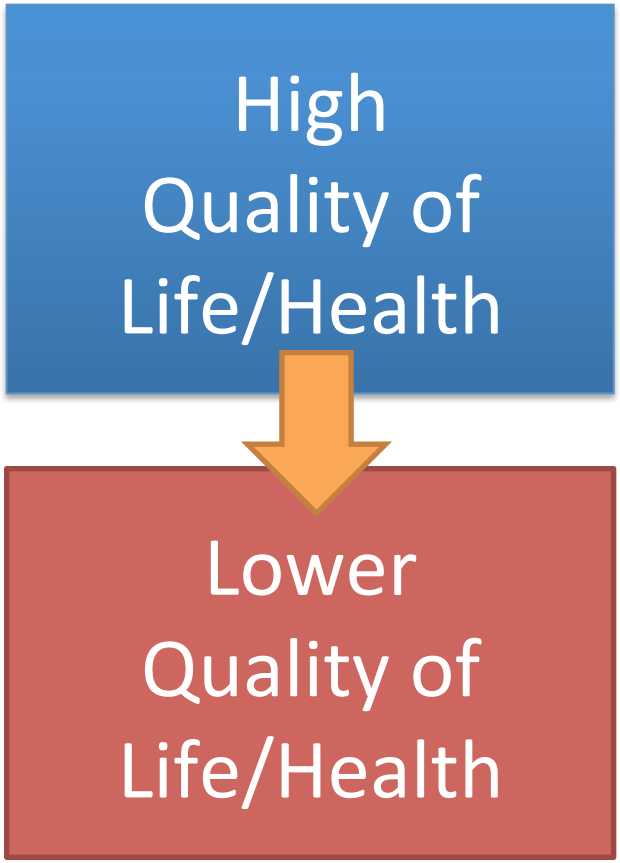


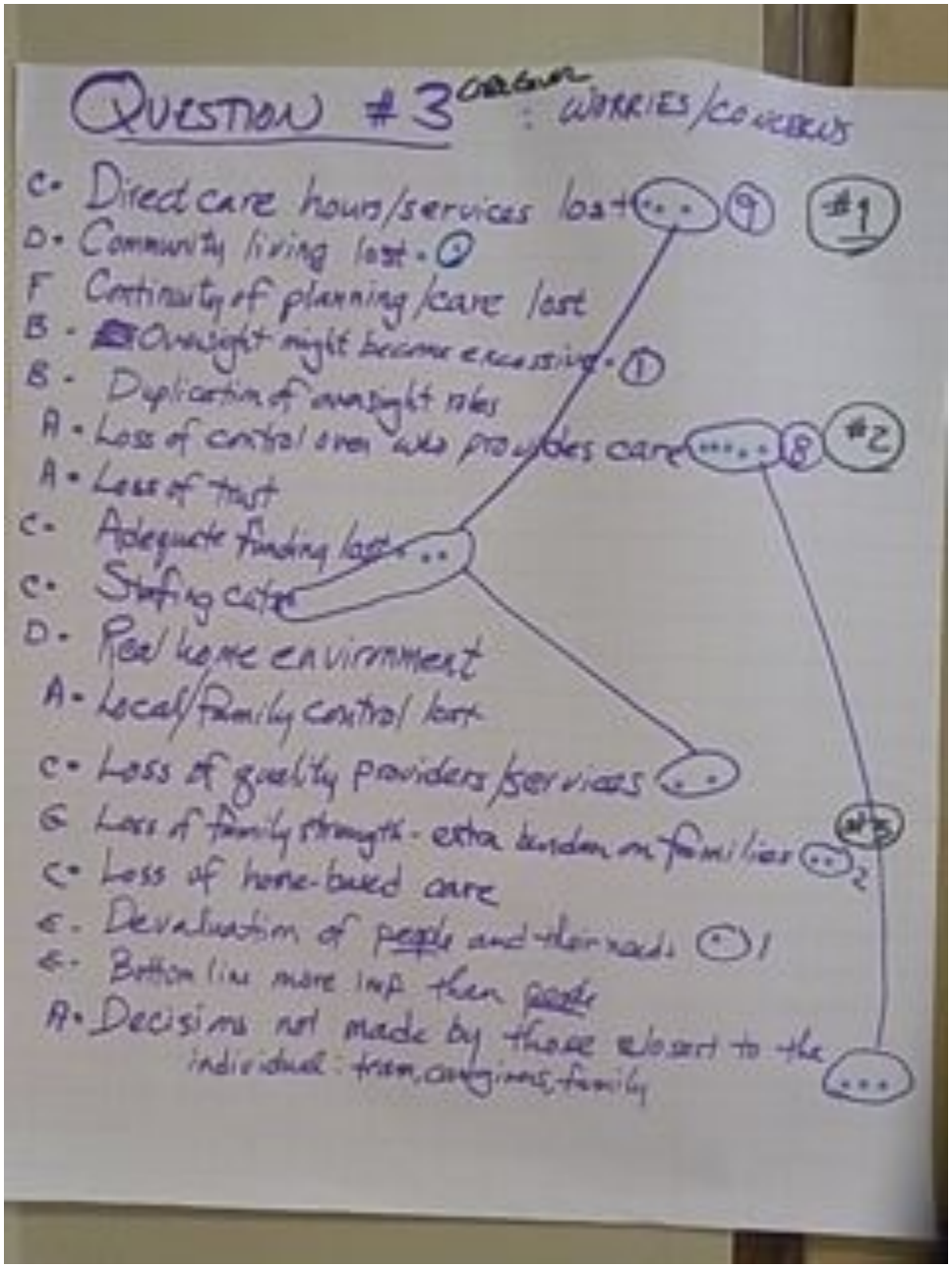

QUESTION #2
A Get out of the way of the team - let the team make the decisions
B Opportunities for growth
C Local control
D Increase relationship building
E Have choices...
F Non - institutional environment
G Best care/practices
H Make application process easier
Less paperwork / less management / more direct care
I Encourage innovation/out of the box
J In accord w/ recipient's values
K Adequate, respectful compensation for provider

Recipient Perspective – Exercise 3

Supports you are concerned care management might remove

- Adequate funding and staffing
- Loss of control over who controls the care
- Decisions will not be made by individuals close to caregivers
- Extra burden based on families



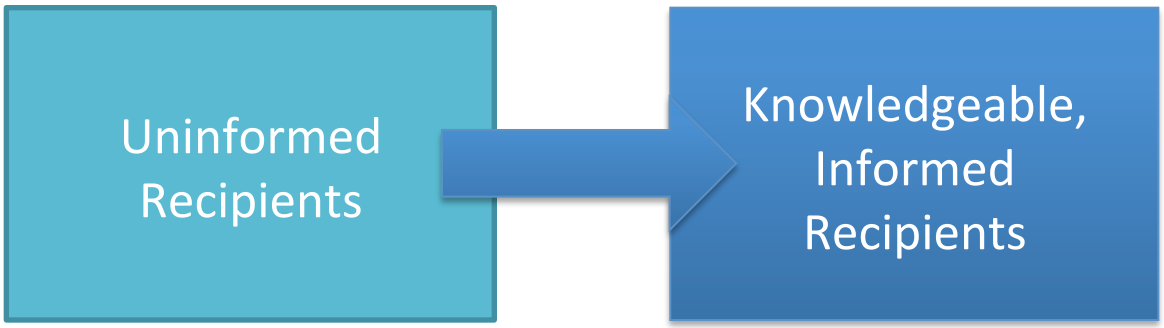


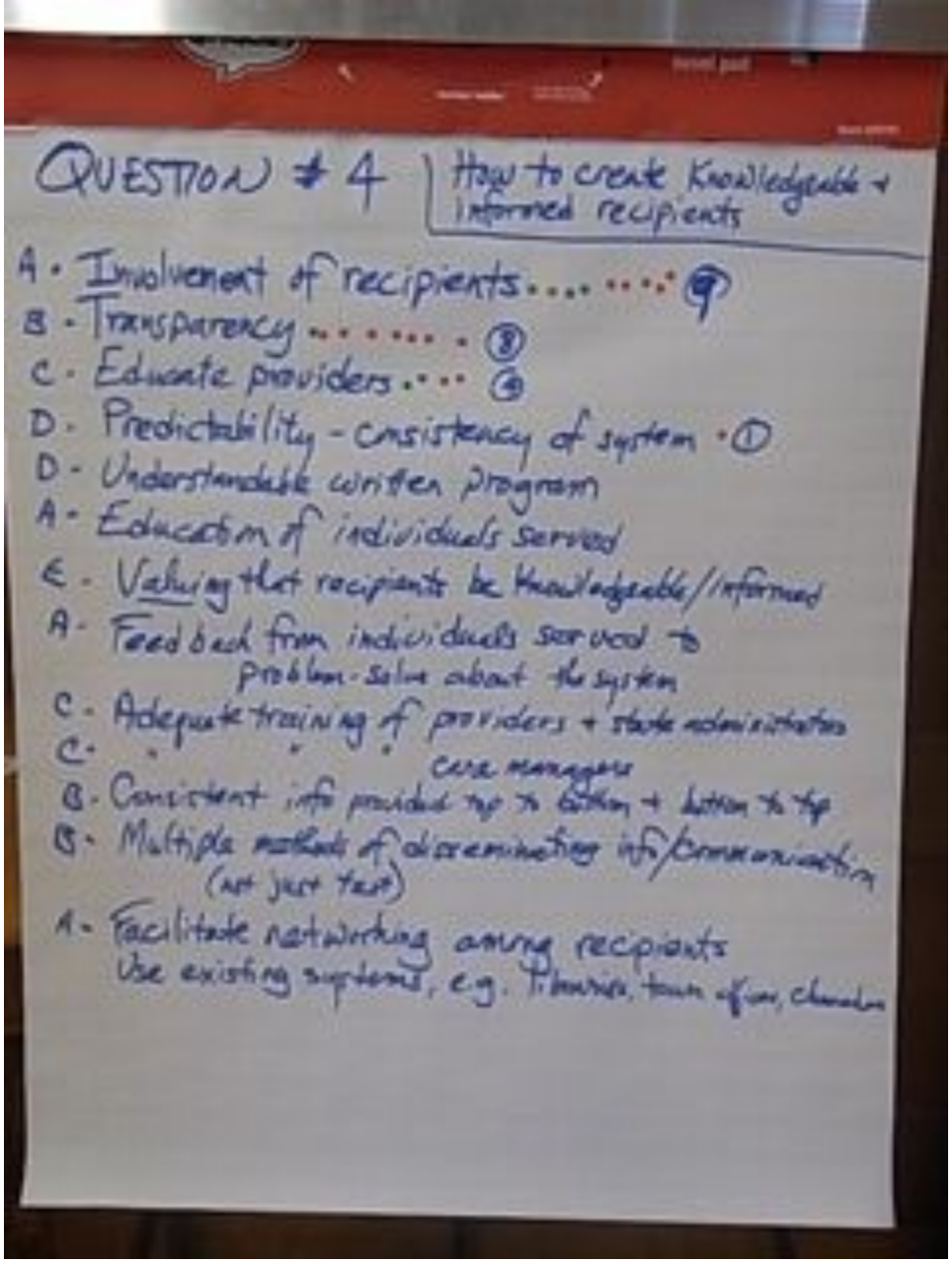
Medicaid Forum Documentation Keene, NH 9/13/2011

Recipient Perspective – Exercise 4

What must happen to create knowledgable and informed recipients?

- Involvement of the recipients including feedback to problem solve about system
- Facilitated networking among recipients
- Transparency
- Consistency of Information
- Multiple methods of disseminating information
- Education of providers including State Administrators

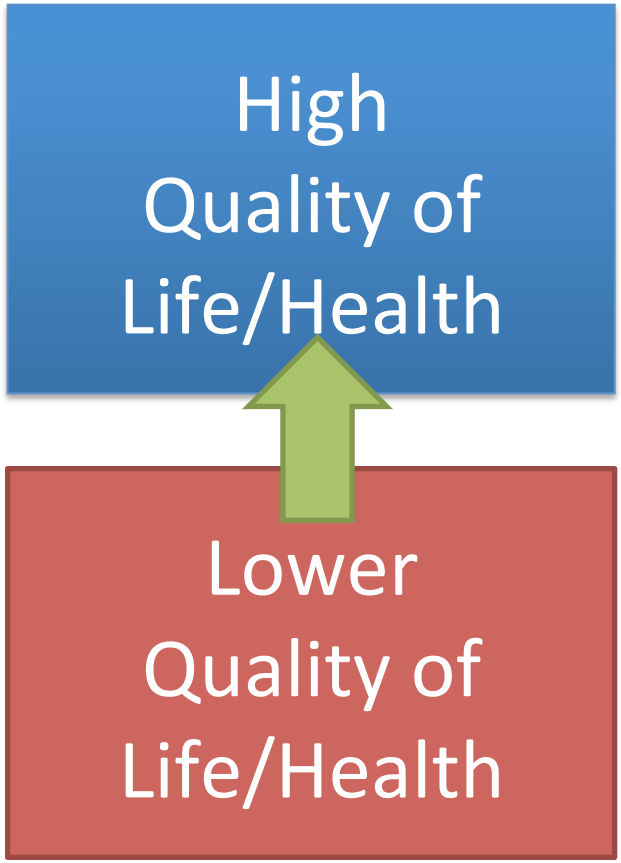


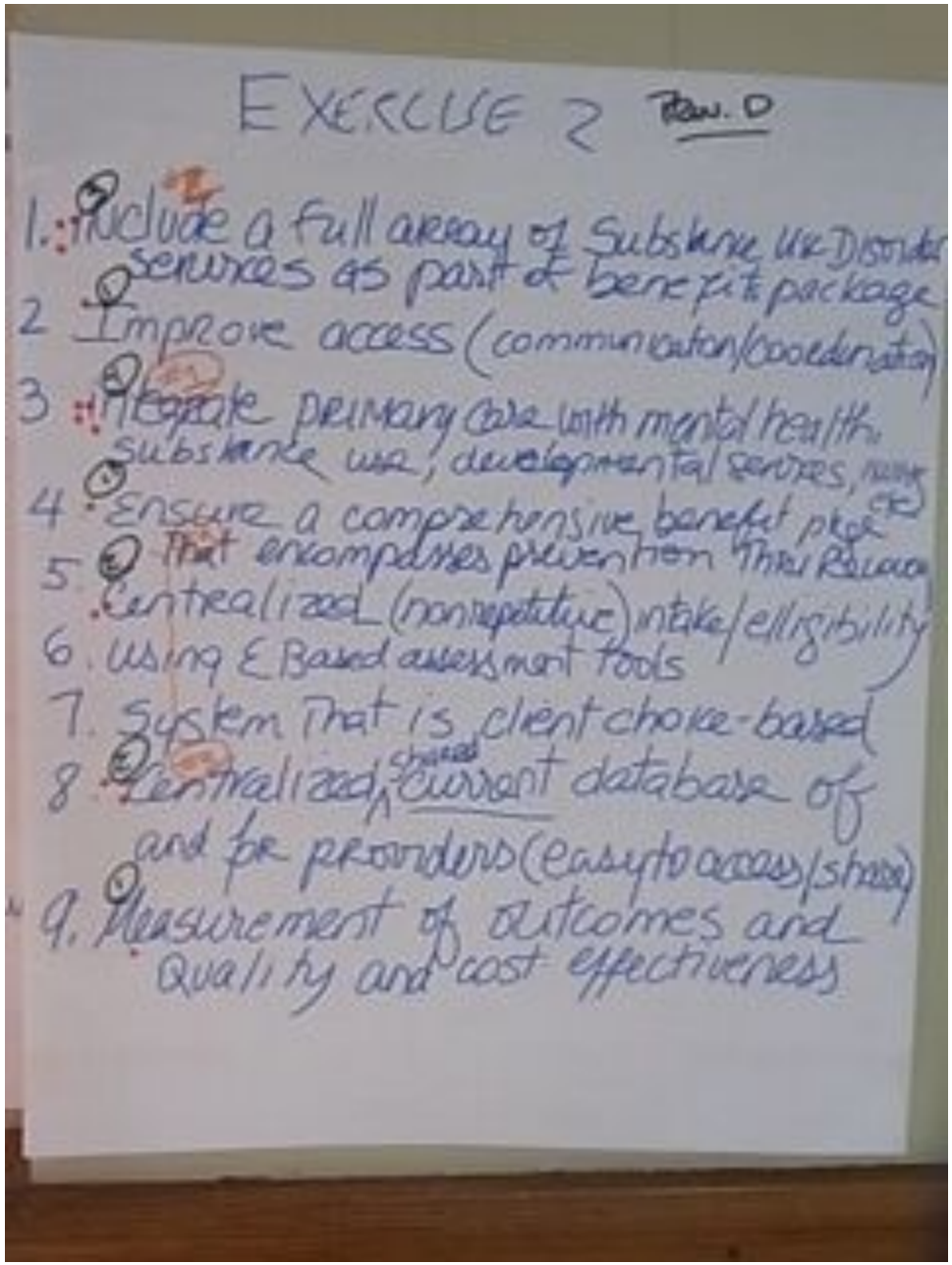

QUESTION # 4
How to create Knowledgeable + informed recipients
A - Involvement of recipients ..... (9)
B - Transparency ..... (8)
C - Educate providers .... (4)
D - Predictability - consistency of system - (1)
D - Understandable written program
A - Education of individuals served
E - Valuing that recipients be knowledgeable/informed
A - Feedback from individuals served to problem-solve about the system
C - Adequate training of providers + state administrators
C - care managers
B - Consistent info provided top to bottom + bottom to top
B - Multiple methods of dissemination info/communication (not just text)
A - Facilitate networking among recipients
Use existing systems, e.g. libraries, town offices, churches

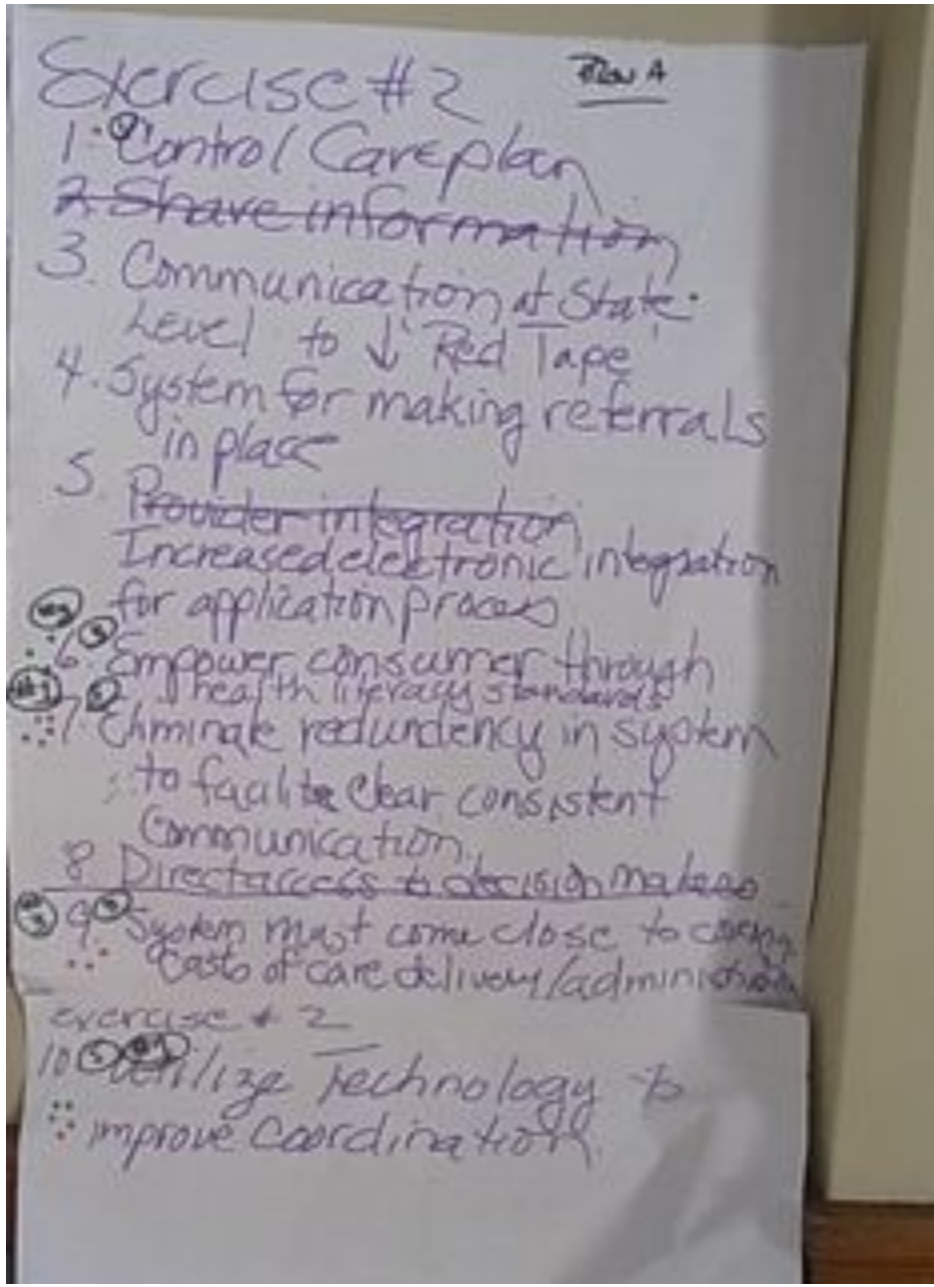
Provider Perspective – Exercise 2

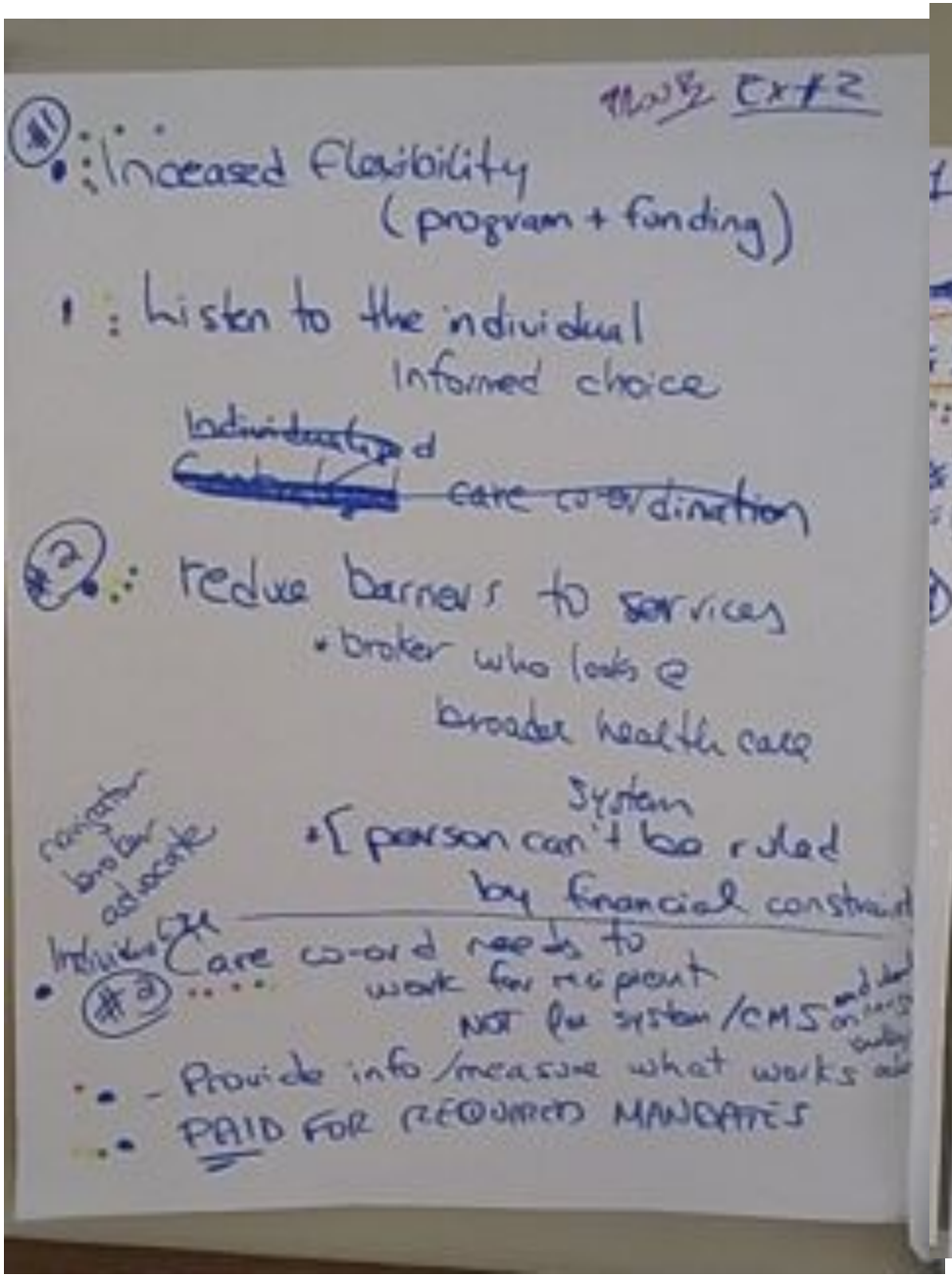
What's needed to increase # with high quality of life/health

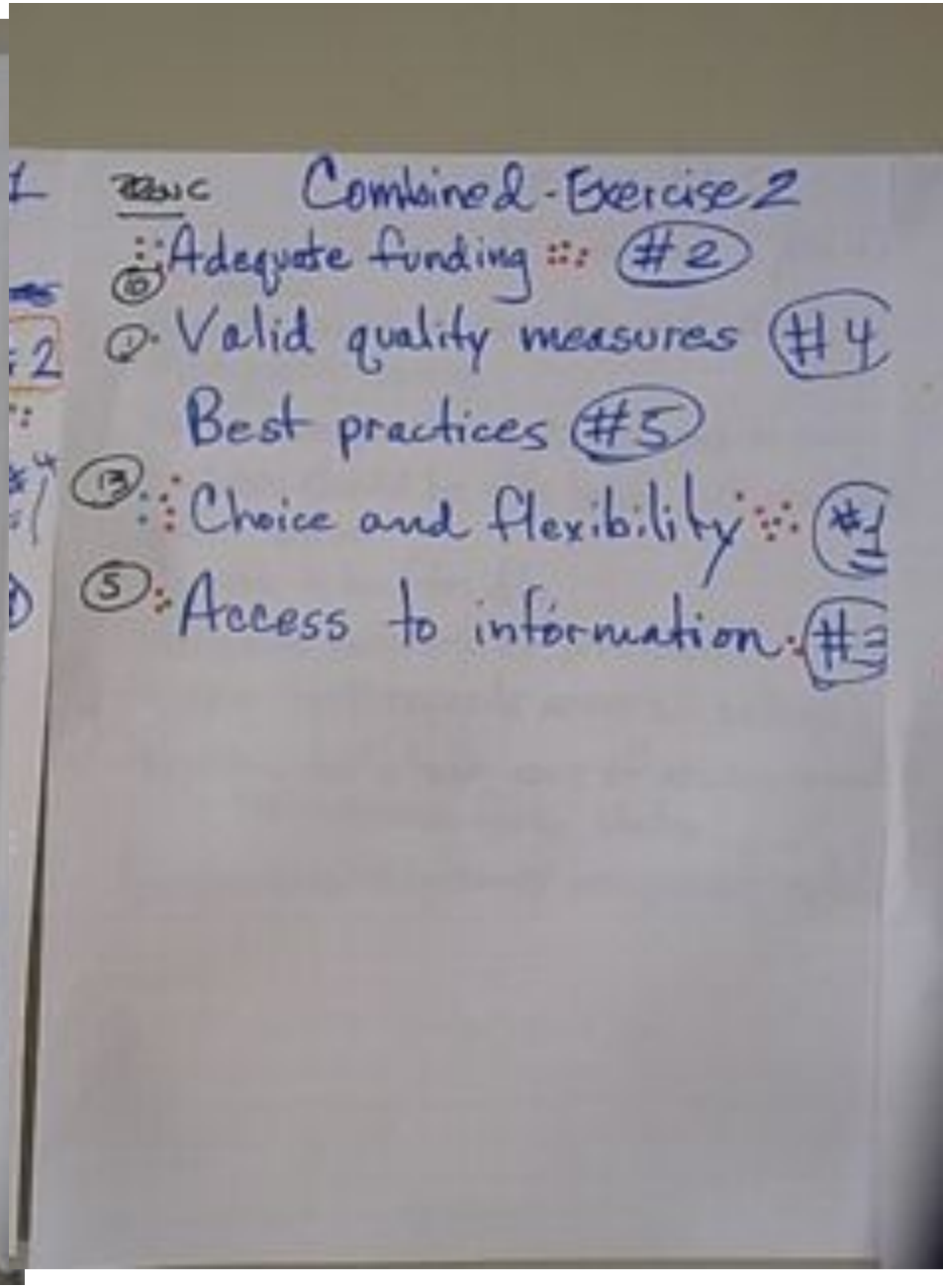
- Integrate primary care with mental health, substance abuse, developmental services, nursing, etc
- Including a full array of substance abuse disorder services as part of benefits package
- Centralized, shared, current database of and for providers that is easy to access and shared.
- Eliminating redundancy within provider system to facilitate clear consistent communication
- Utilize technology to improve coordination
- Empower consumers through health literacy standards
- Care coordinator needs to work for the consumer, not for the system
- Choice and flexibility
- Adequate Funding
- Access to Information
- Cover cost of care delivery and administration
- Increased flexibility of programing and funding
- Reduction of barriers to services – a broker who looks at the broader care needs whose decisions are NOT based on finances




EXERCISE 2 Rev. D
1. Include a full array of Substance Use Disorder services as part of benefit package
2 Improve access (communication/coordination)
3 Integrate primary care with mental health, substance use, developmental services, etc
4 Ensure a comprehensive benefit plan
5 That encompasses prevention Tiers Recovery
Centralized (non-repetitive) intake/eligibility
6. Using E Based assessment tools
7. System that is client choice-based
8 Centralized, shared current database of and for providers (easy to access/share)
9. Measurement of outcomes and Quality and cost effectiveness

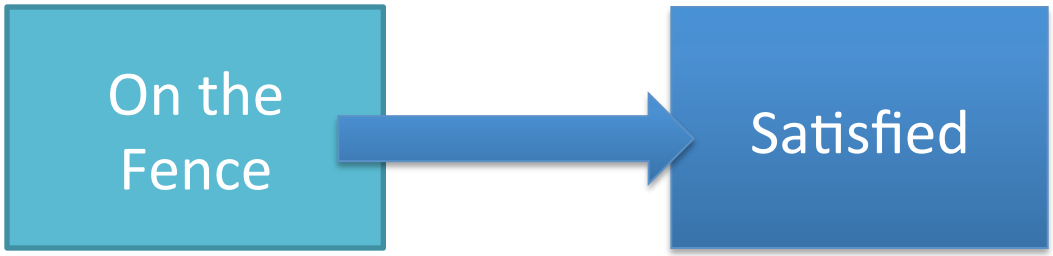

Exercise #2 Rev A
1. Control Careplan
2 Share information
3. Communication at State level to ↓ Red Tape
4. System for making referrals in place
5. Provider integration
Increased electronic integration for application process
6. Empower consumer through health literacy standards
7. Eliminate redundancy in system to facilitate clear consistent communication.
8 Direct access to decision makers
9. System must come close to covering Costs of care delivery/administration
exercise # 2
10 Utilize technology to improve coordination.


Increased Flexibility
(program + funding)
1 : Listen to the individual
Informed choice
care coordination
2 : reduce barriers to services
• broker who looks @
broader health care
System
• [person can't be ruled
by financial constraint
navigator
broker
advocate
Care co-ord needs to
work for recipient
NOT the system/CMS
- Provide info/measure what works
PAID FOR REQUIRED MANDATES

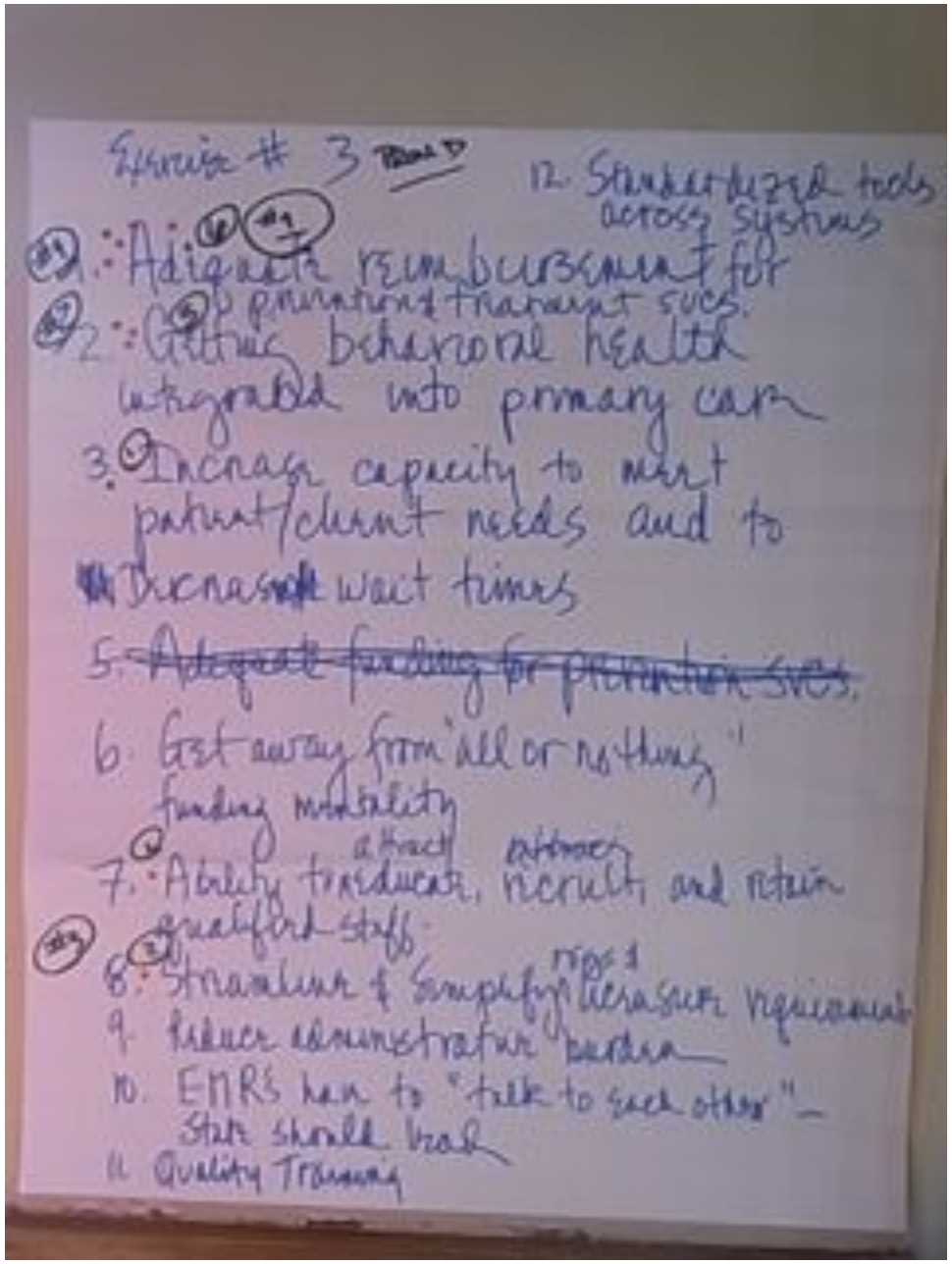

Combined-Exercise 2
Adequate funding :: #2
Valid quality measures #4
Best practices #5
Choice and flexibility :: #1
Access to information :: #3

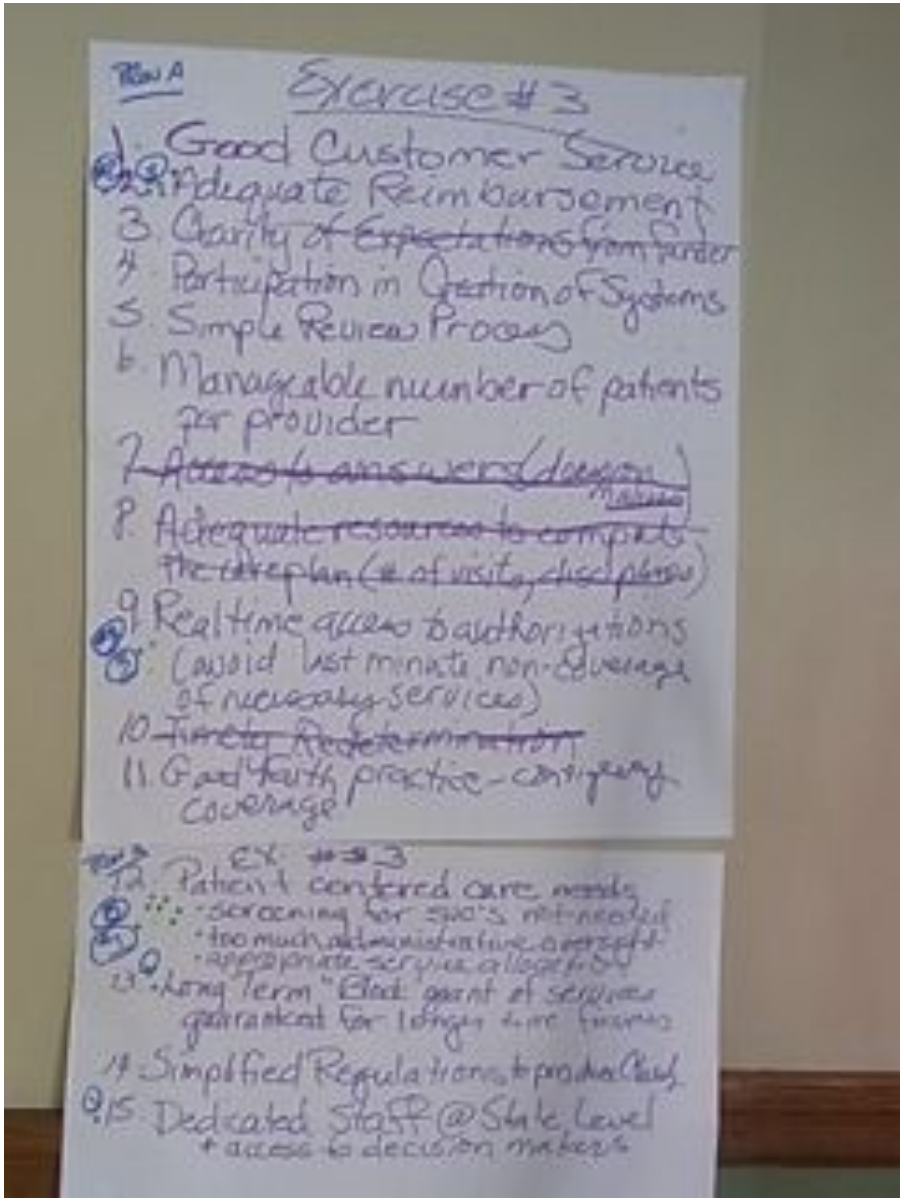
Provider Perspective – Exercise 3

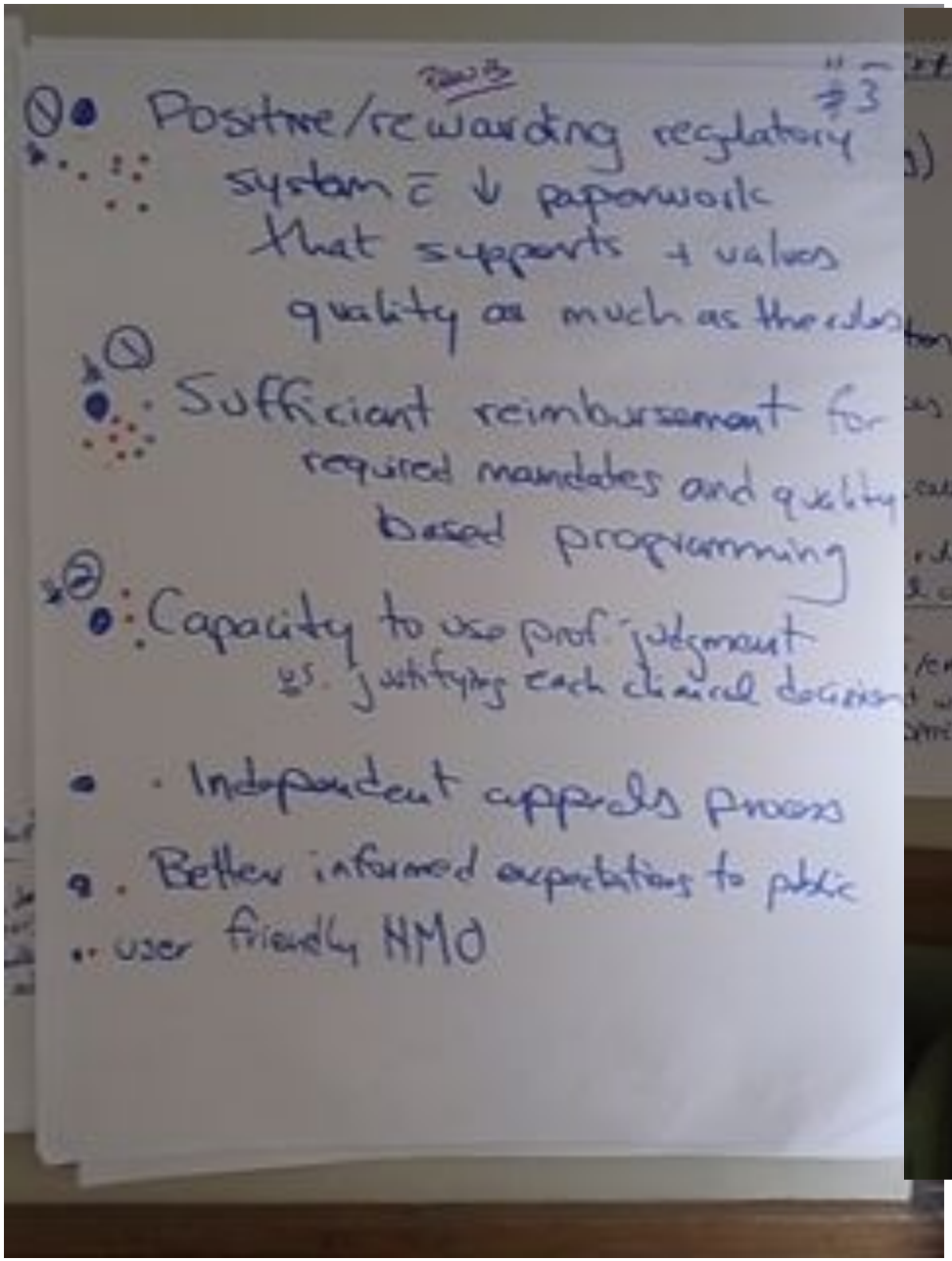
What's needed to satisfy providers

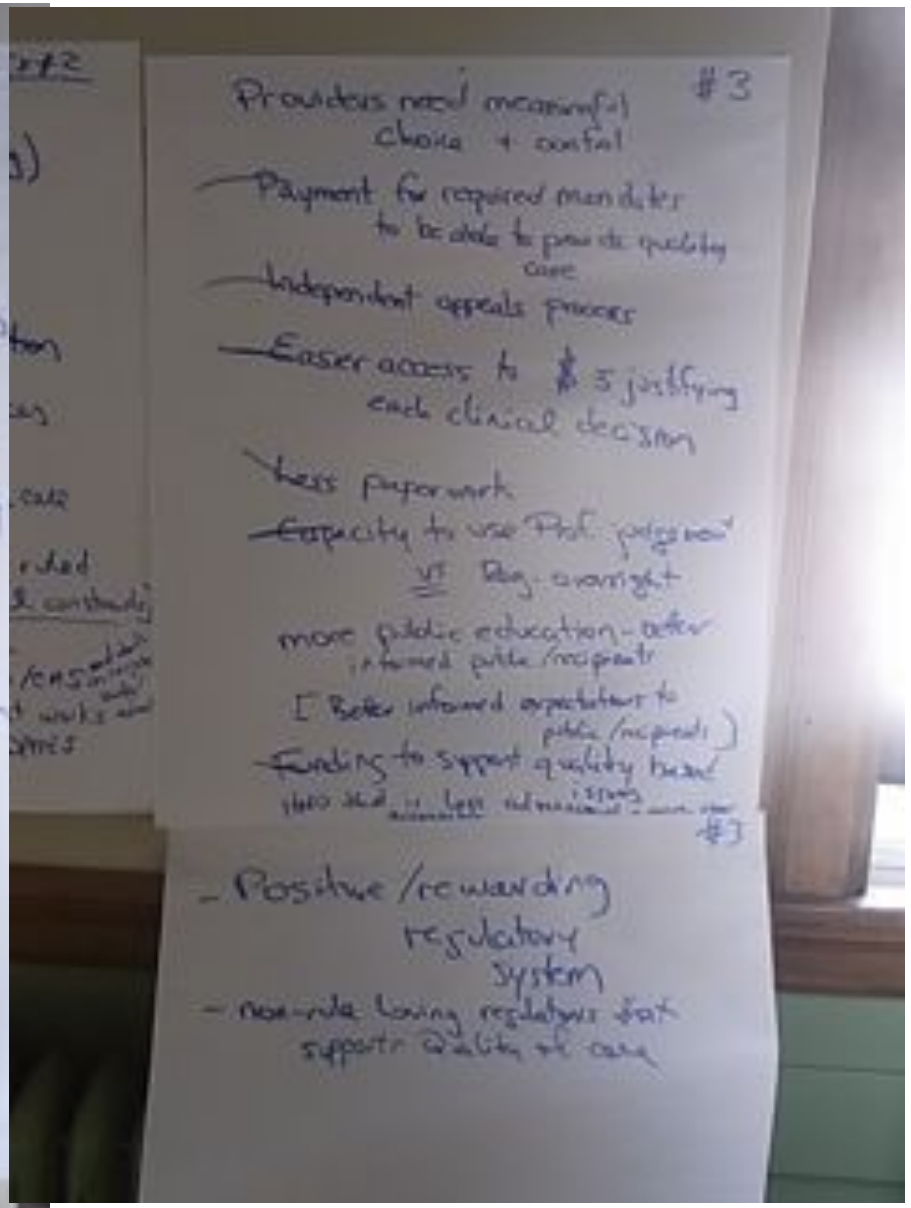


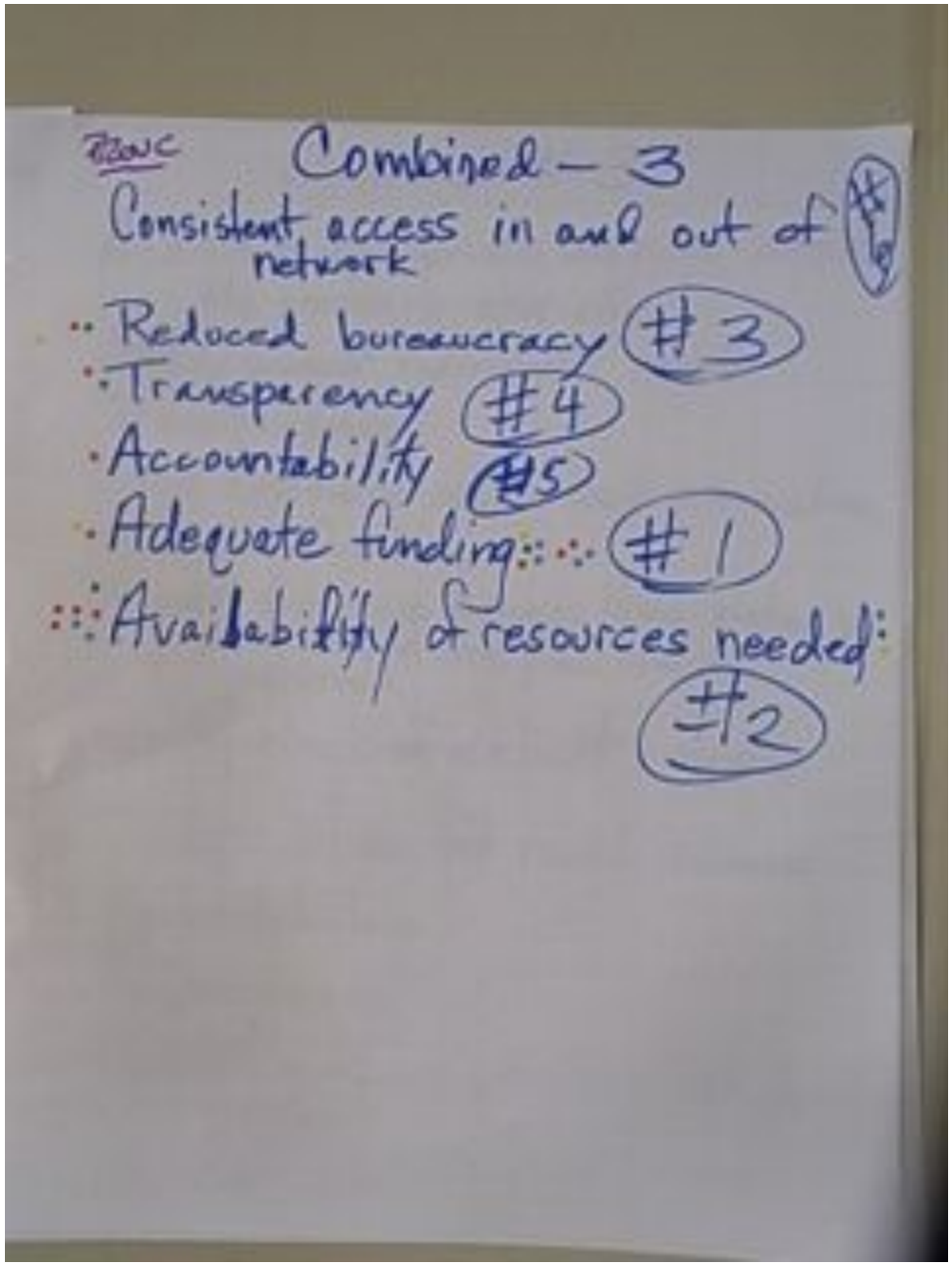
- Adequate reimbursement *3
- Behavioral health integrated into primary care
- Streamline and simplify licensure and regulatory requirements
- Have the system be patient centered – screening for services not needed, too much admin oversight, appropriate service allocation Real time access to authorizations
- Positive and rewarding regulatory framework with low paperwork and respect for quality
- No more unfunded mandates
- Capacity for caregivers to use professional judgment rather than having to
- Availability of resources needed to serve patients
- Reduced bureaucracy


Exercise # 3
12. Standardized tools across systems
1. Adequate reimbursement for
2. Integrate behavioral health integrated into primary care
3. Increase capacity to meet patient/client needs and to
Decrease wait times
5. Adequate funding for prevention svcs.
6. Get away from "all or nothing" funding modality
7. Ability to educate, recruit, and retain qualified staff.
8. Streamline & Simplify regs & paperwork requirements
9. Reduce administrative burden
10. EMRs have to "talk to each other" — State should lead
11. Quality Training


Exercise #3
1. Good Customer Service
2. Adequate Reimbursement
3. Clarity of Expectations from Payer
4. Participation in Creation of Systems
5. Simple Review Process
6. Manageable number of patients per provider
7. Access to answers/decision making
8. Adequate resources to complete the treatment plan (# of visits, discipline)
9. Real time access to authorizations
10. Timely Redetermination
11. Good faith practice - contingency coverage
Ex. #3
12. Patient centered care needs
- screening for svc's not needed
- too much administrative oversight
- appropriate service allocation
13. "Long Term" Block grant of services guaranteed for longer time frames
14. Simplified Regulations to provide Care
15. Dedicated Staff @ State Level + access to decision makers


#3
Positive/rewarding regulatory system ↓ paperwork that supports + values quality as much as the
Sufficient reimbursement for required mandates and quality based programming
Capacity to use prof. judgment vs. justifying each clinical
Independent appeals process
Better informed expectations to public
user friendly HMO

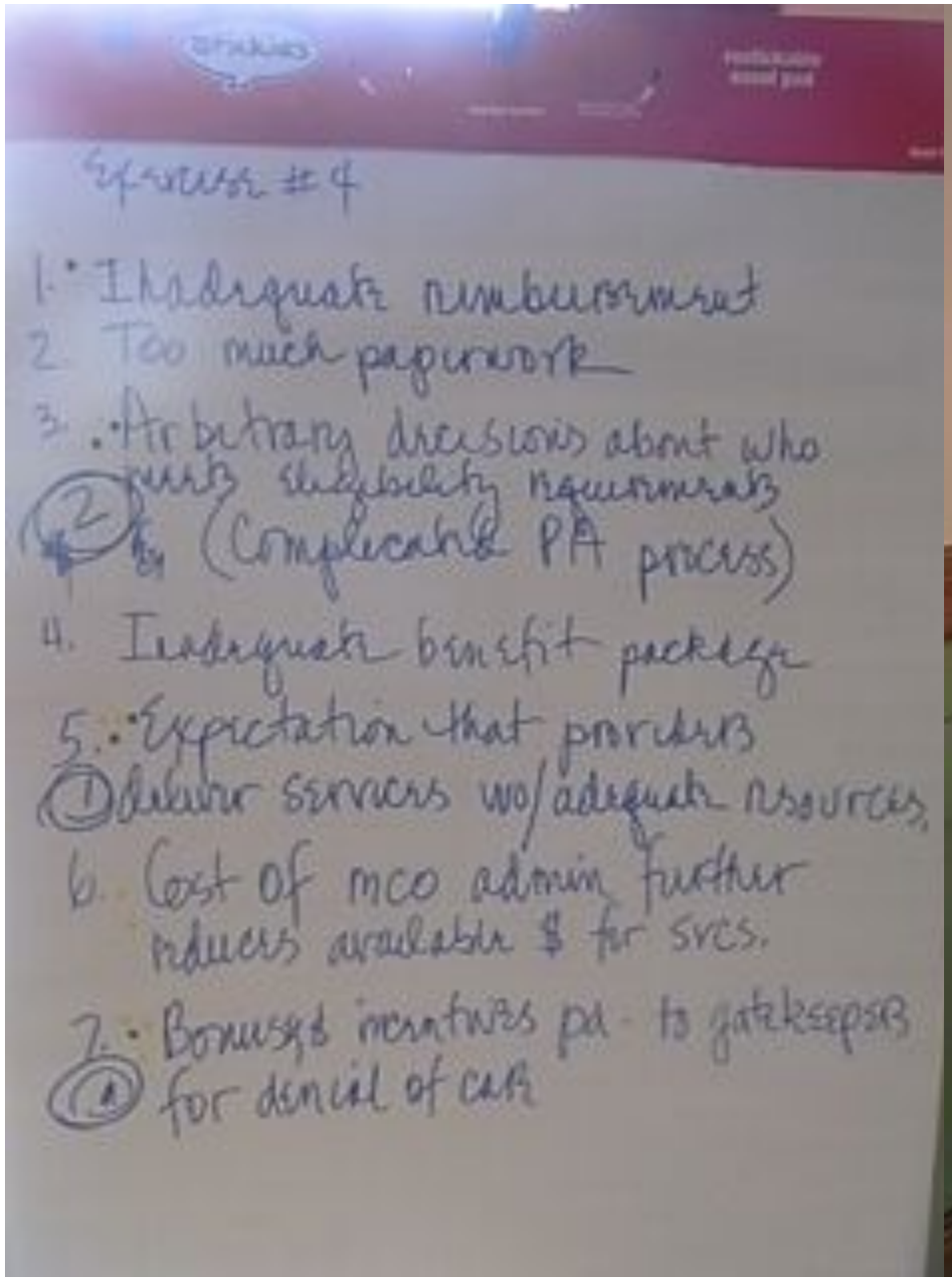

#3
Providers need meaningful choice + control
Payment for required mandates to be able to provide quality care
Independent appeals process
Easier access to $ justifying each clinical decision
less paperwork
Capacity to use Prof. judgment vs Reg. oversight
more public education - better informed public/recipients
[Better informed expectations to public/recipients]
Funding to support quality based
#3
- Positive/rewarding regulatory system
- non-rule basing regulations that support Quality of care

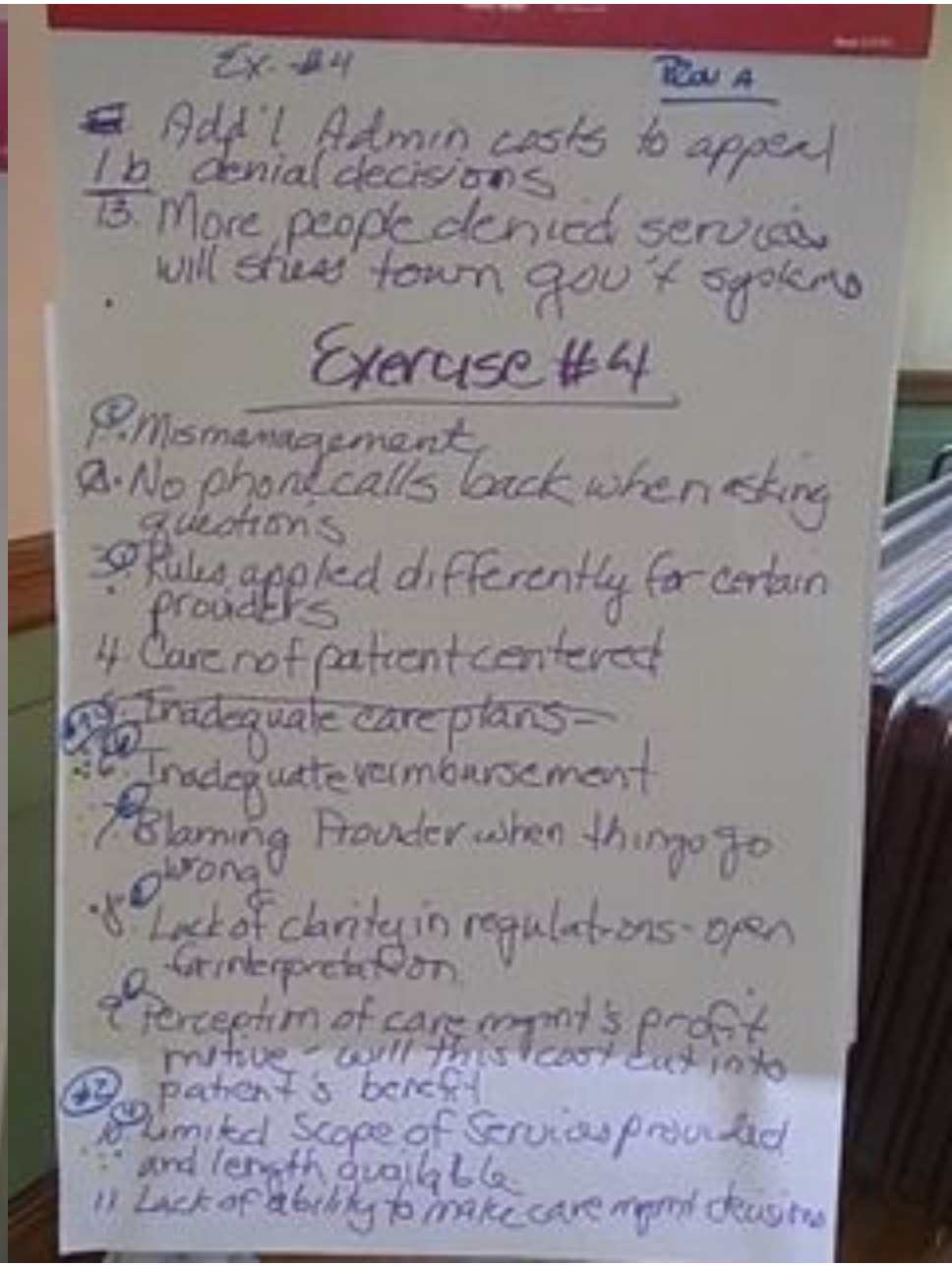

Combined – 3
Consistent access in and out of network
#6
Reduced bureaucracy
#3
Transperency
#4
Accountability
#5
Adequate funding
#1
Availability of resources needed
#2

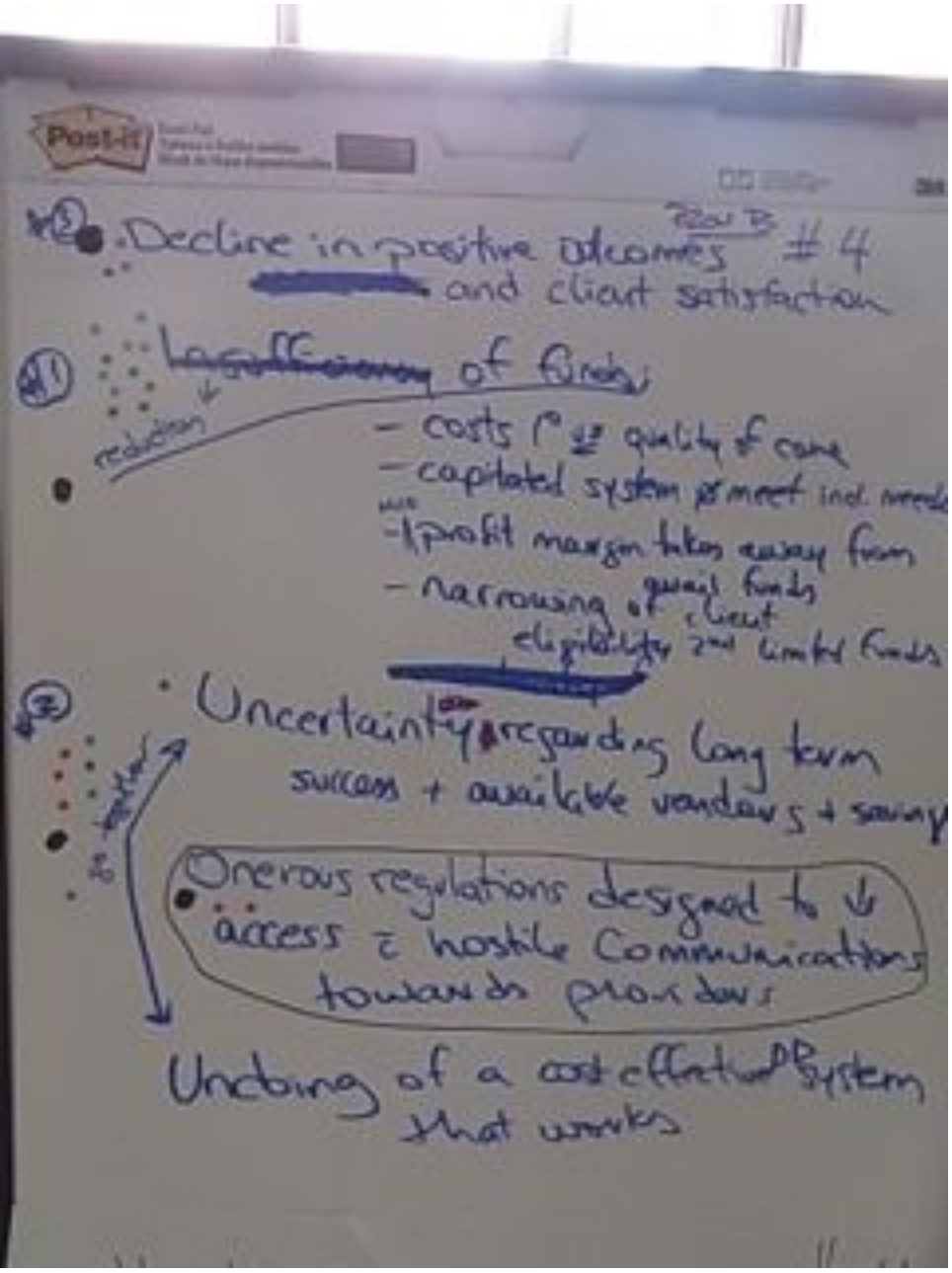
Provider Perspective – Exercise 4

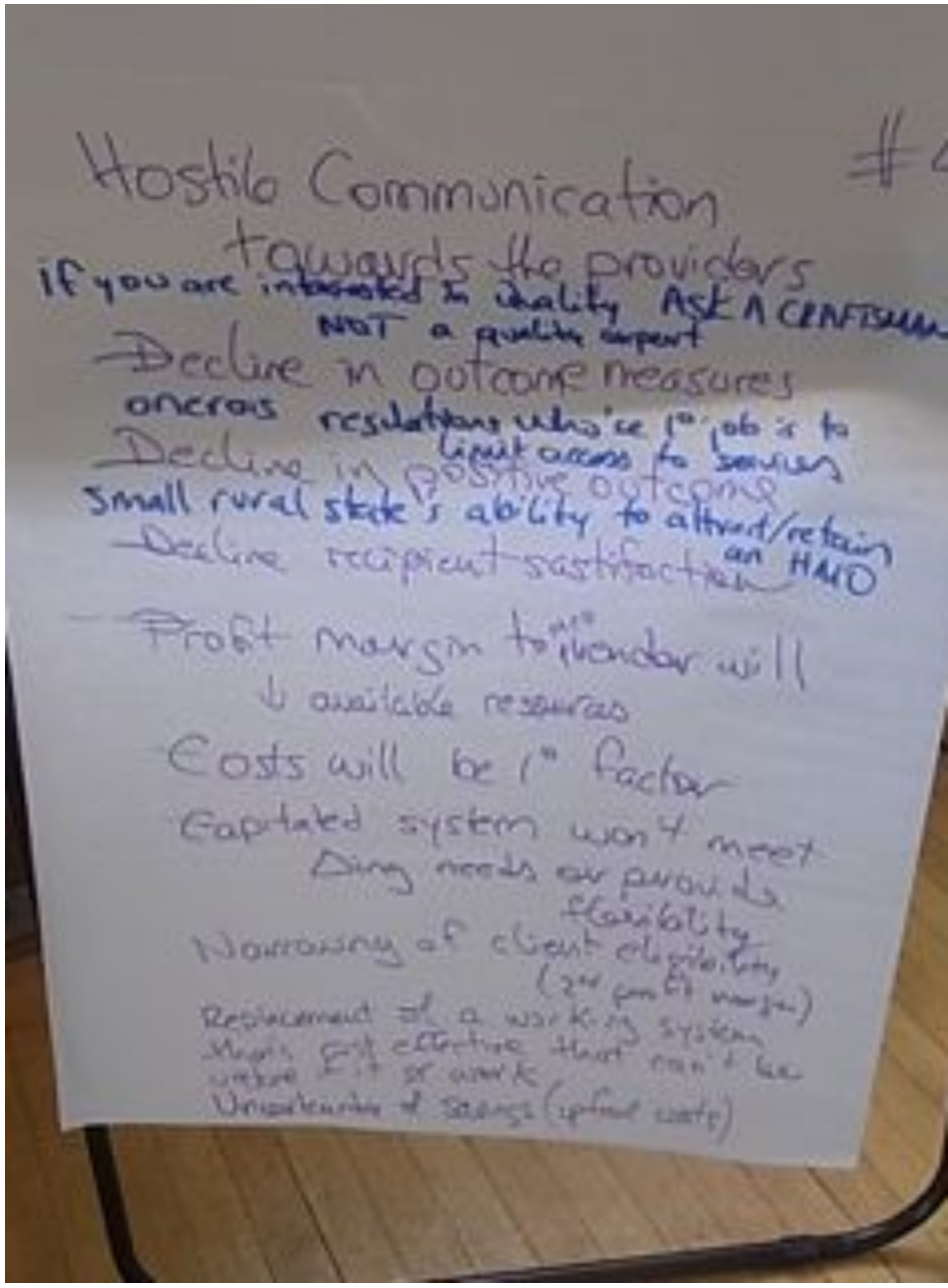
What might create resistant providers

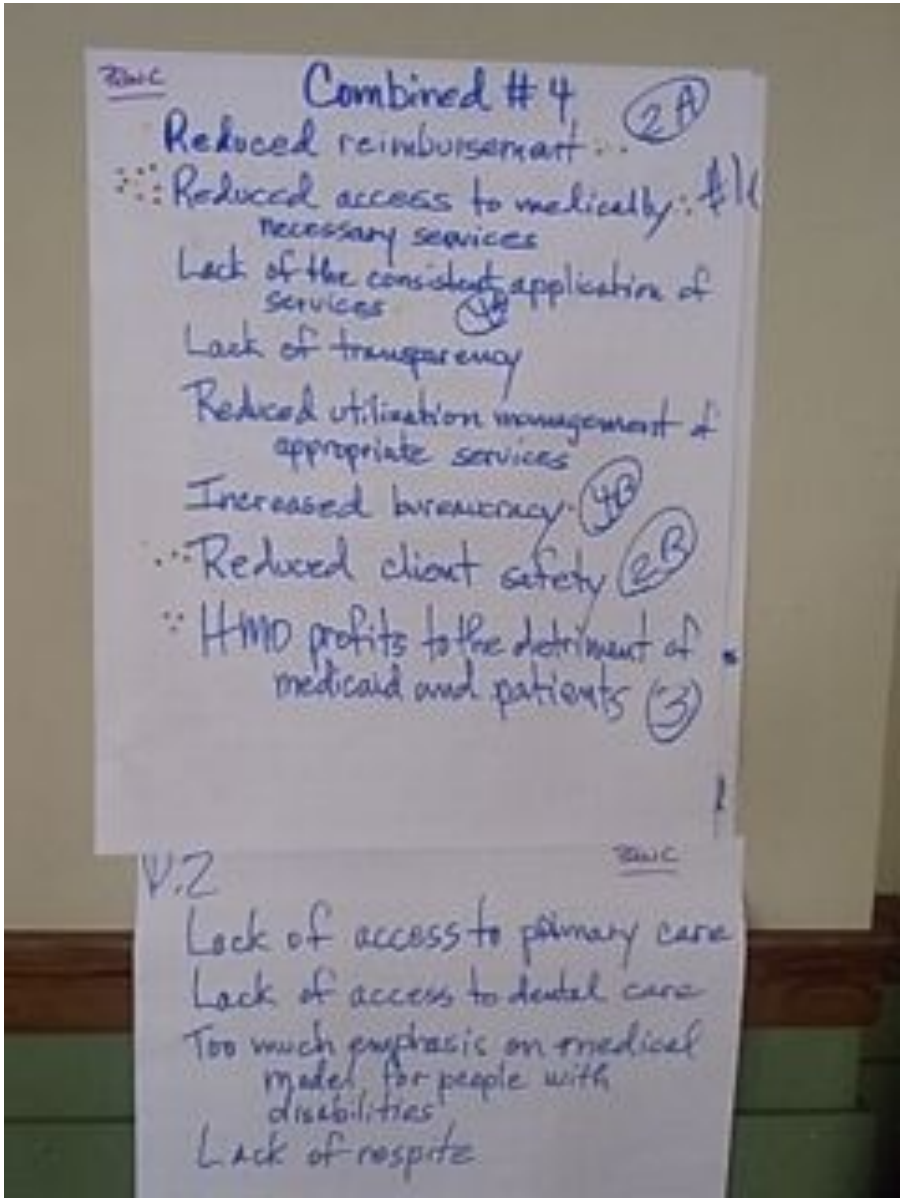
- **Reduced reimbursement**
- Reduced access to medically necessary services
- Reduced client safety
- Reduction in funds – costs become more important than quality…unmet individual needs…NCO profit margins
- Uncertainty regarding long term success and vendors…Undoing of a cost effective system that works
- Decline in positive outcomes and client satisfaction
- Limited scope of services provided and length of availability diminished
- Expectations that providers deliver with inadequate resources
- Bonuses and incentives paid to gatekeepers for denials of care
- Arbitrary decisions about who gets care


Exercise #4
1. Inadequate reimbursement
2. Too much paperwork
3. Arbitrary decisions about who meets eligibility requirements
(Complicated PA process)
4. Inadequate benefit package
5. Expectation that providers deliver services w/o adequate resources
6. Cost of mco admin further reduces available $ for svcs.
7. Bonuses incentives pd to gatekeepers for denial of care


Ex #4
Rev A
Add'l Admin costs to appeal denial decisions
More people denied services will stress town gov't systems
Exercise #4
Mismanagement
No phone calls back when asking questions
Rules applied differently for certain providers
Care not patient centered
Inadequate care plans
Inadequate reimbursement
Blaming Provider when things go wrong
Lack of clarity in regulations - open to interpretation
Perception of care mgmt's profit motive - will this cost cut into patient's benefit
Limited Scope of Services provided and length available
Lack of ability to make care mgmt decisions


Post-it
Decline in positive outcomes and client satisfaction
#4
Lack of funds
reduction
- costs ↑ & ↓ quality of care
- capitated system ∅ meet ind. needs
- profit margin takes away from
- narrowing of client eligibility & limited funds
Uncertainty regarding long term success + available vendors + savings
restricted
Onerous regulations designed to ↓ access & hostile Communications towards providers
Undoing of a cost effective system that works


#4
Hostile Communication towards the providers
if you are interested in quality ASK A CERTIFIED
NOT a quality expert
Decline in outcome measures
onerous regulations who's 1° job is to limit access to services
Decline in positive outcome
small rural state's ability to attract/retain an HMO
Decline recipient satisfaction
Profit margin to vendor will ↓ available resources
Costs will be 1° factor
Capitated system won't meet Ding needs or provide flexibility
Narrowing of client eligibility (2nd profit margin)
Replacement of a working system Medicaid that can't be undone if it doesn't work
Uncertainty of savings (upfront costs)


Combined #4
Reduced reimbursement (2A)
Reduced access to medically necessary services
Lack of the consistent application of services
Lack of transparency
Reduced utilization management & appropriate services
Increased bureaucracy (4B)
Reduced client safety (2B)
HMO profits to the detriment of medicaid and patients (3)
V.2
Lack of access to primary care
Lack of access to dental care
Too much emphasis on medical model for people with disabilities
Lack of respite

NH Medicaid
Care Management Program
Public Forum

Nashua, NH

September 14, 2011

Recipient AND Provider Perspective – Exercise 1

For someone receiving Medicaid, what defines having the highest quality life/health?

- Access to & affordability of quality care Ability to reach maximum potential/goals
- Choice in services including who and where.
- Comprehensive, well coordinated, quality care that is evidence-based and comparable. Self directed and self-fulfilling
- Local, adequate and competent provider system.
- Whole person perspective for health and services (including activities of daily living) across the lifespan.
- Access right care at the right time...nothing unneeded Effective communication between providers.
- Barrier-free access to community or home-based individual care (similar to the consumer directed model we have today)
- Choice - of doctor, services, dental and where and when you want to go
- Maintenance of best medical and social health and freedom to be active in the community and as independent as possible.
- Respect - no bias, indistinguishable from non medicaid citizens
- Quality opportunities including day program, socialization, recreation, employment
- Ease of enrollment

Recipient Perspective - Exercise 2

What's needed to increase # with high quality of life/health?

- New system must ensure an adequate number of quality providers and services for REAL choice (CDS/FDS for ALL people and no waitlist) with welcoming PCP and confidence in services.
- More organized group to vote out legislators
- Integrated physical/social/pshychological health with INDIVIDUALLY designed services ensuring easy and convenient access.
- Knowledge of availability, eligibility, and list of of providers (including out of network) that is user friendly and accessible.
- Adequate funding & reimbursement
- Increased access and quality provider network and programming including out of state.
- Community based programming
- Care Management with timely processing, record keeping, information on rules and decisions, with knowledgeable and caring managers that works well with private insurance and includes caregivers and families in planning.

Provider Perspective – Exercise 2

What's needed to increase # with high quality of life/health

- Services that are evidence based, efficient, affordable, and easy to evaluate.
- Innovative support designs that afford consumers freedom, flexibility, and individual choice.
- Providers that focus on PREVENTION
- Ability to refer client to ALL needed services, not just menu, including meds
- Care plan developed WITH client to meet needs.
- Need access to info and training in a timely manner.

Recipient Perspective – Exercise 3

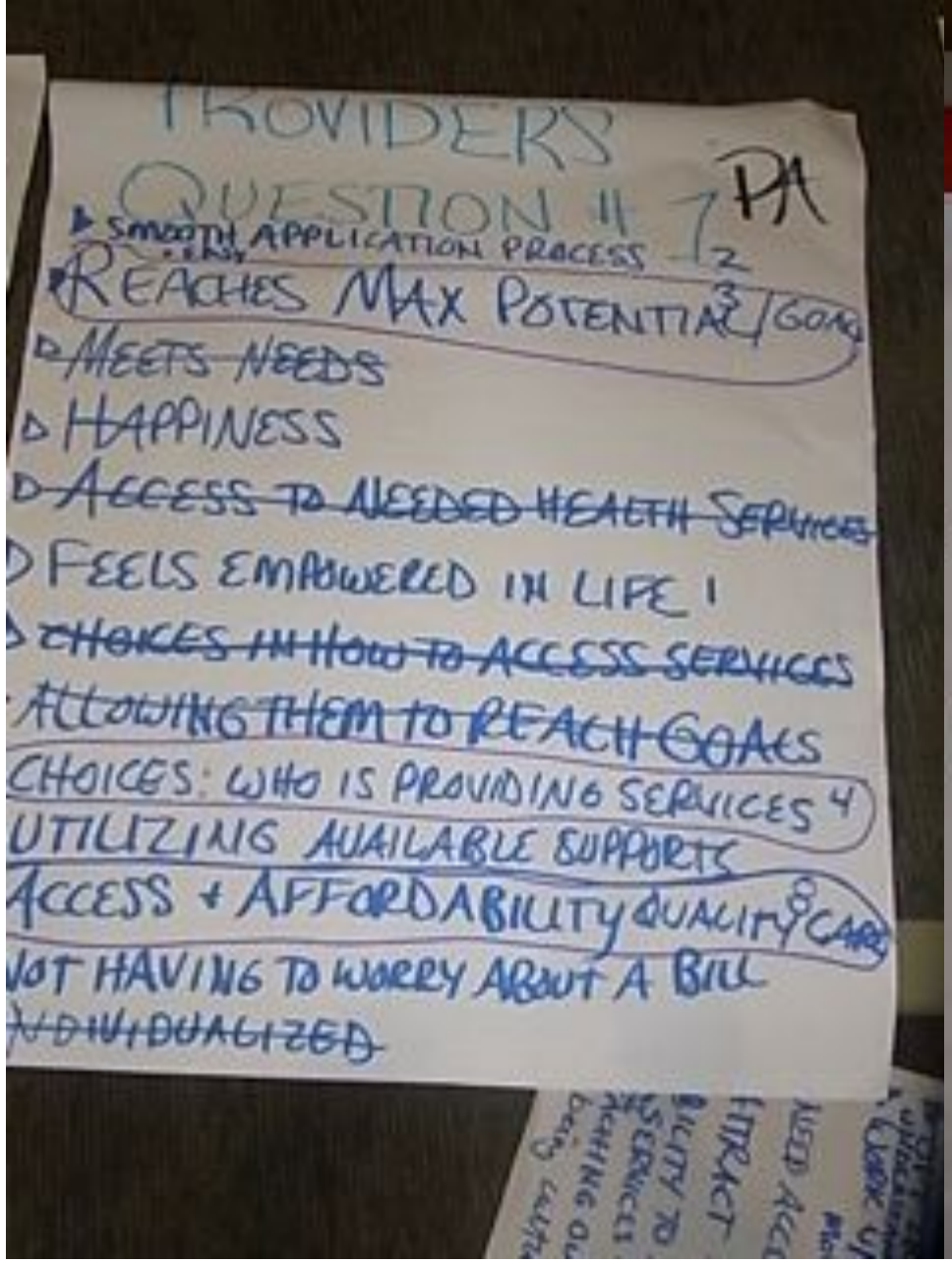
In a care management program, what must happen in order to create **knowledgeable and informed** recipients?

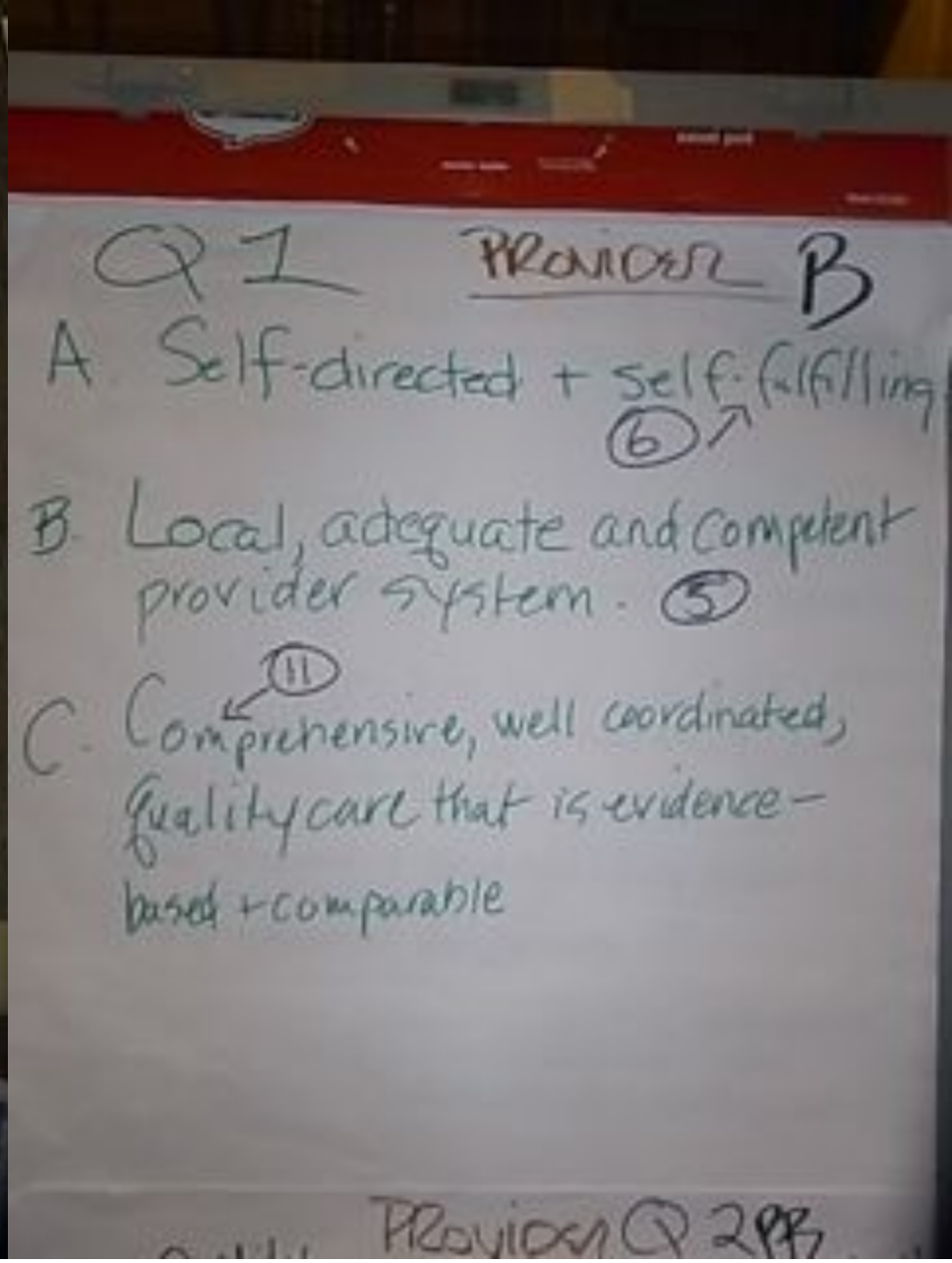
- GOOD COMMUNICATION - easy access to REAL people, strong and clear communication from DHHS regarding the process and development of Medicaid managed care as it evolves, an a strong, reliable, MULTFACETED communication system.
- Area agencies elder care service link should remain the way they are today.
- Strong case management with no conflict (not a payor or service provider)
- System cannot be overly complicated and must be both individualized and unified and must include innovative services driven by families and consumers.
- Information infrastructure accessible by first responders and provided to consumers at FIRST CONTACT
- Community based way to disseminate information (including individuals who do NOT speak English), perhaps through the use of a volunteer network.
- Strong case management and advocacy
- Accessible, transparent, comprehensible, multimedia information delivery with access to decision makers.
- Training on consumer directed services for EVERYONE with outreach to new participants, community based organization, and member services, and EVERYBODY

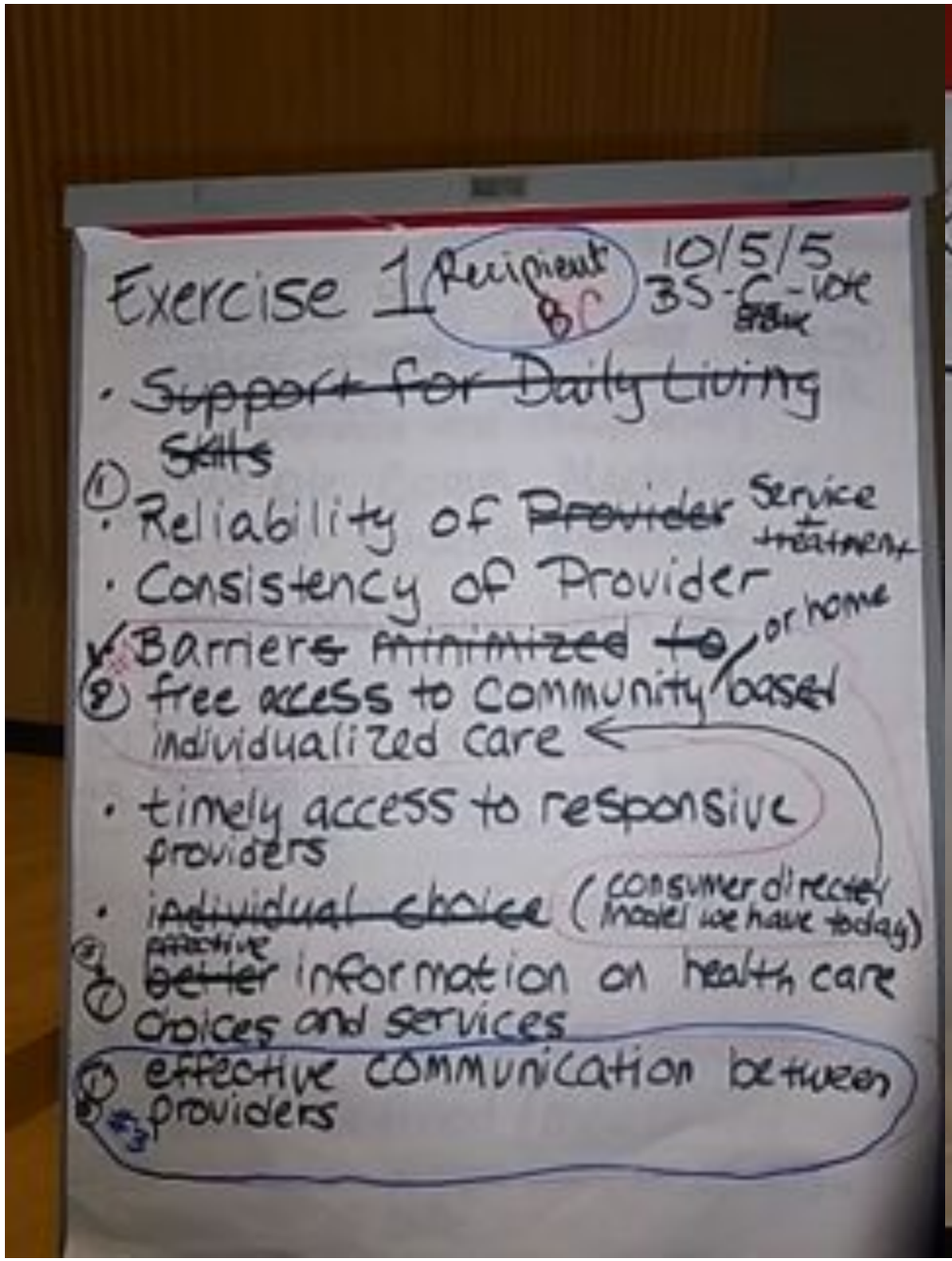
Provider Perspective – Exercise 3

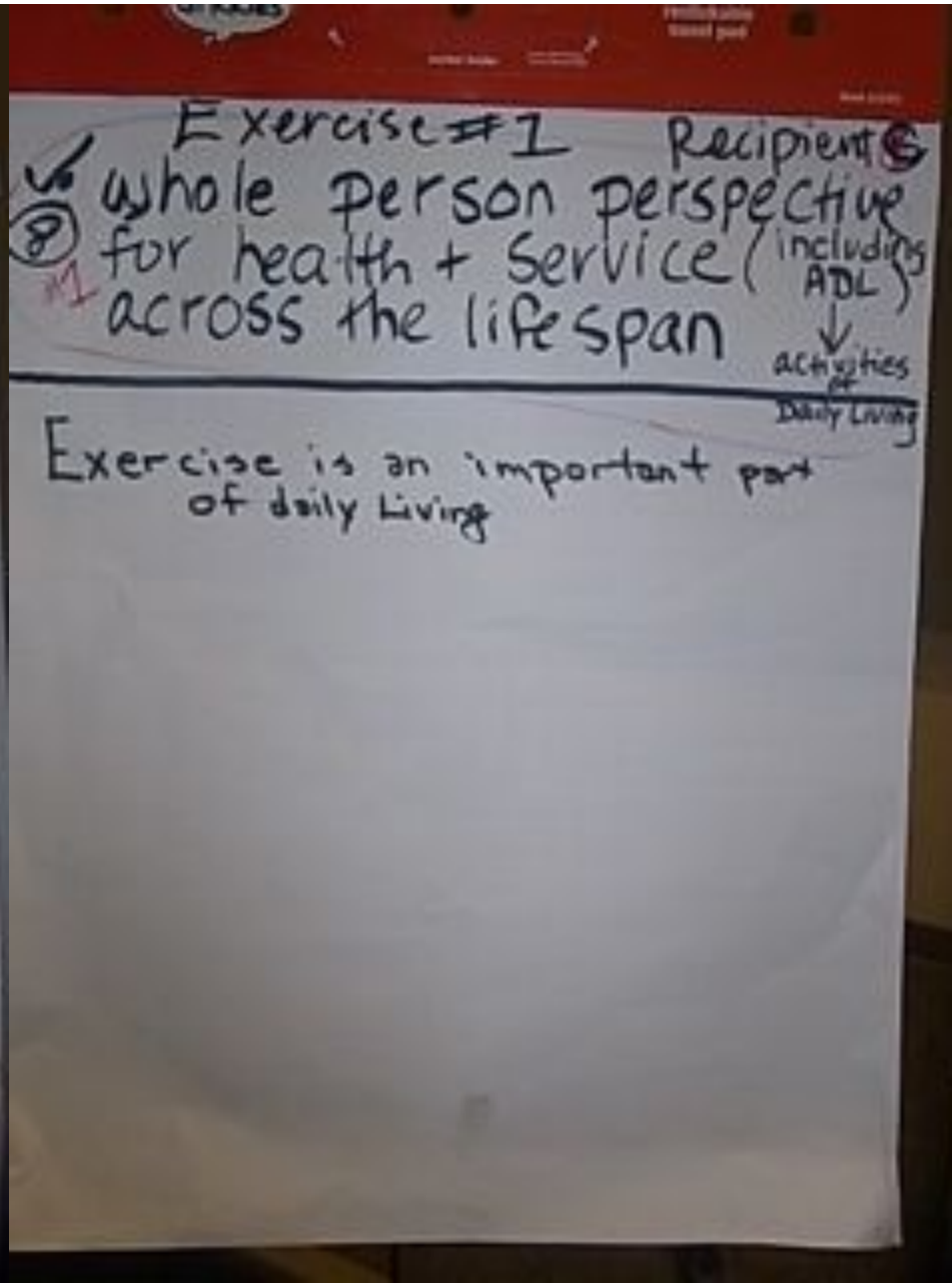
In a care management program, what must happen in order to **create satisfied providers** instead of dissatisfied (or **Resistant**) providers?

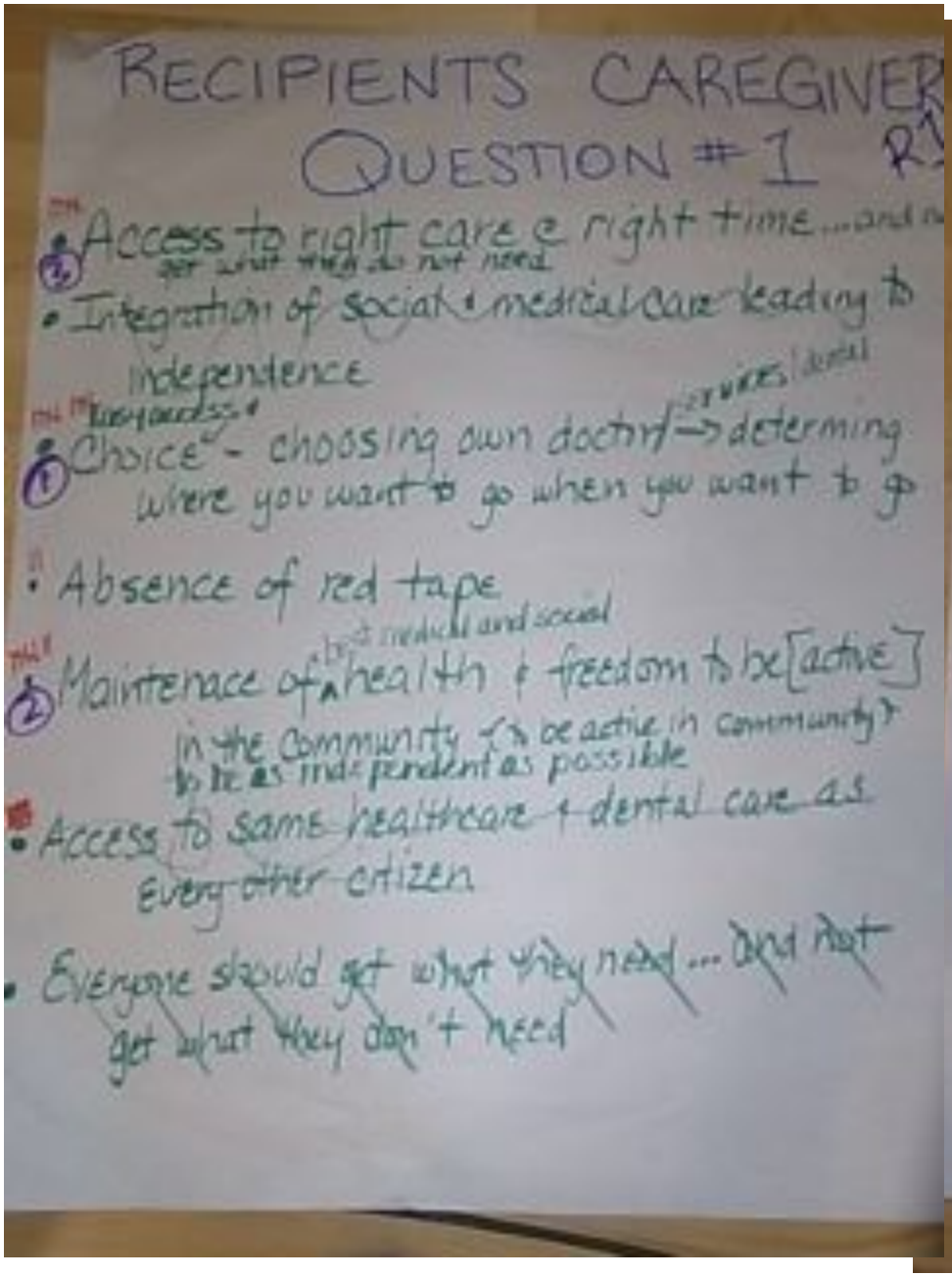
- Fair, creative and timely compensation models that afford providers with financial incentives and rewards for quality outcomes.
- Regulatory structure that is not burdensome and promotes expanded capacity and quality of care
- Establish a statewide, user friendly, affordable health information system that improves care through ease of referral, access, and continuity of care.
- COMMUNICATION - responsiveness, timeliness, clarity of rules and regulations
- Flexibility within structure.
- Client driven NOT $$$ driven.
- Easy to help people navigate through system with minimum barriers.

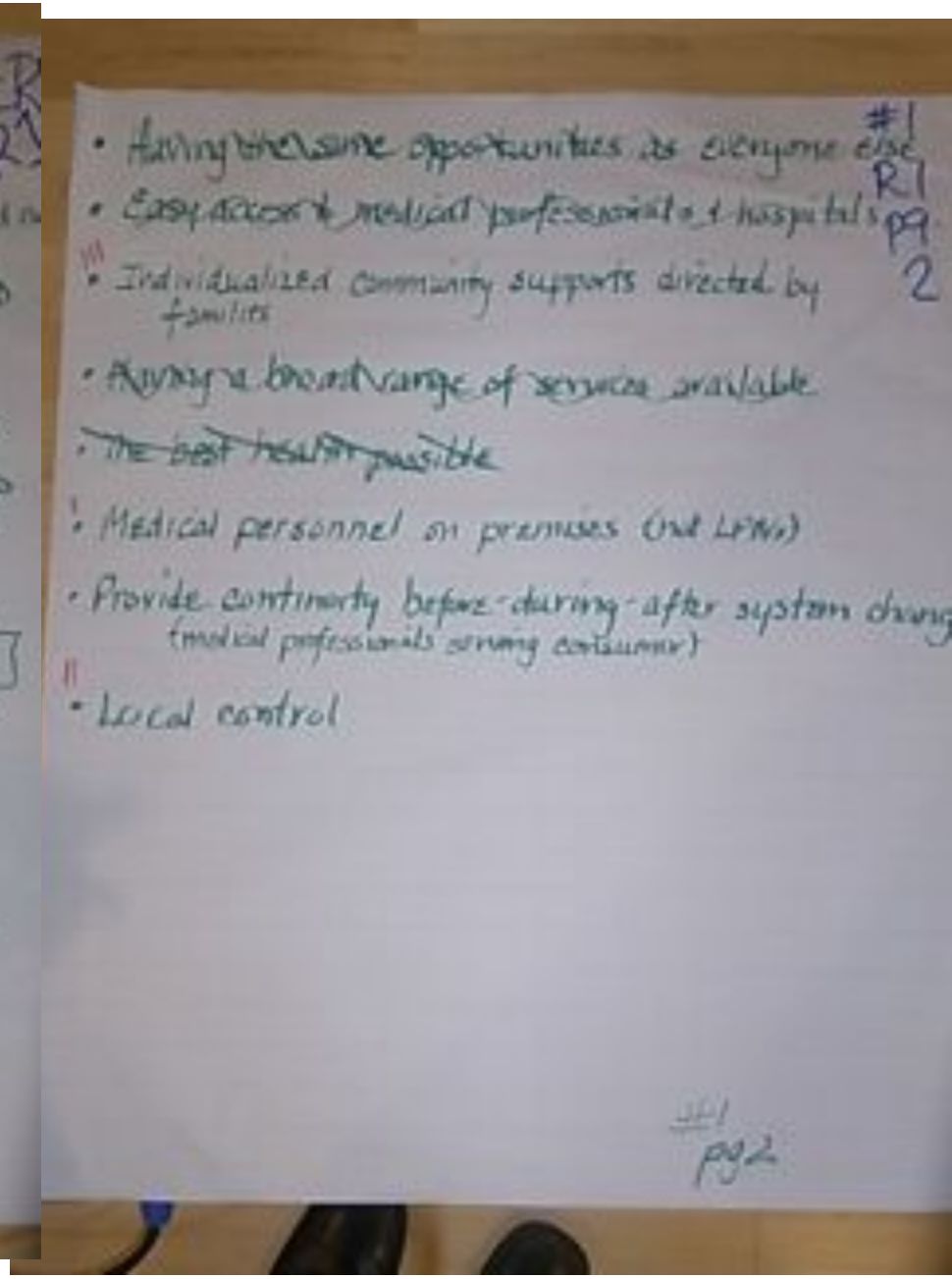

PROVIDERS
QUESTION #1
PA
SMOOTH APPLICATION PROCESS
REACHES MAX POTENTIAL/GOAL
MEETS NEEDS
HAPPINESS
ACCESS TO NEEDED HEALTH SERVICES
FEELS EMPOWERED IN LIFE
CHOICES IN HOW TO ACCESS SERVICES
ALLOWING THEM TO REACH GOALS
CHOICES: WHO IS PROVIDING SERVICES
UTILIZING AVAILABLE SUPPORTS
ACCESS + AFFORDABILITY QUALITY CARE
NOT HAVING TO WORRY ABOUT A BILL
INDIVIDUALIZED

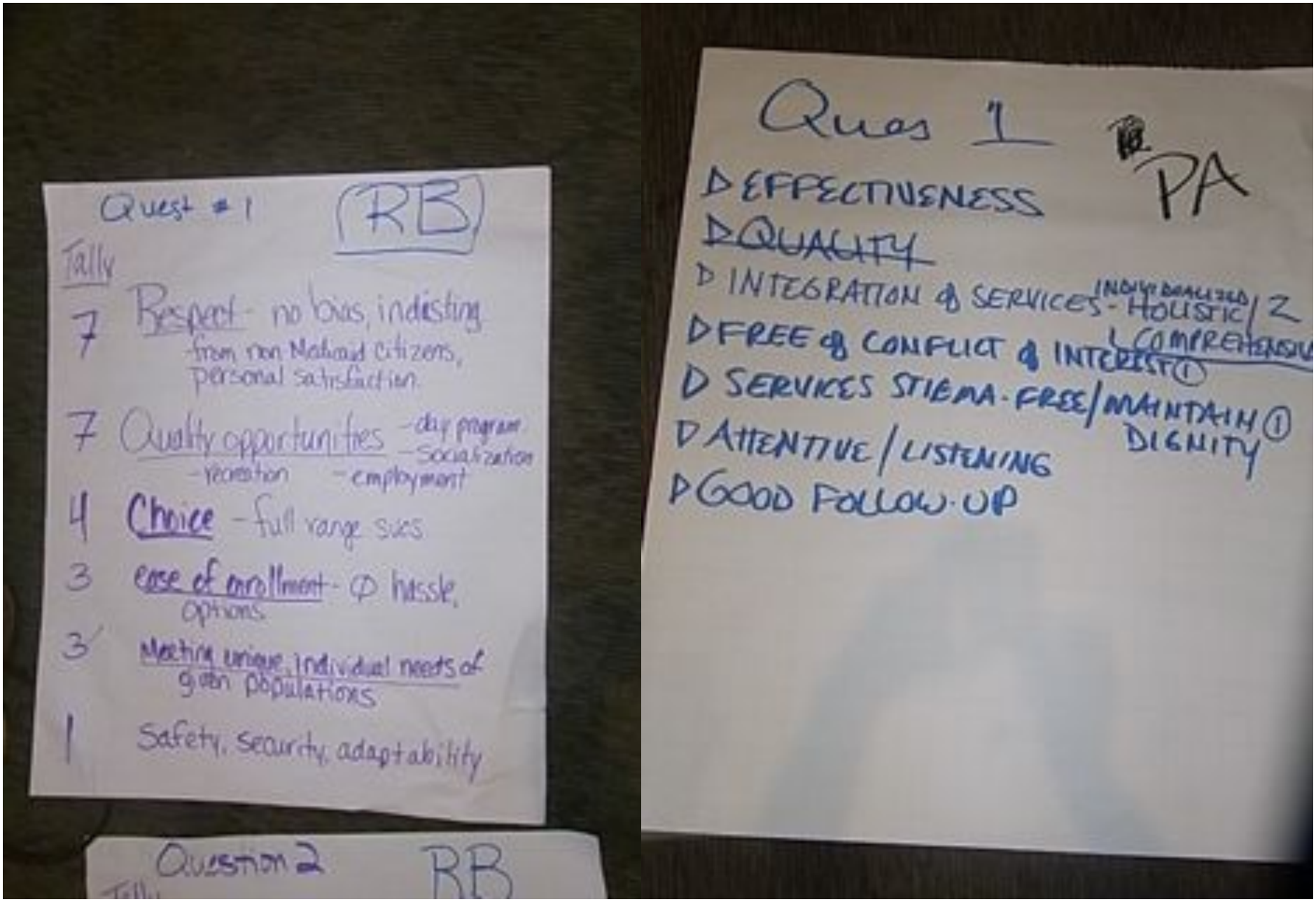

Q1
PROVIDER B
A. Self-directed + self-fulfilling
B. Local, adequate and competent provider system.
C. Comprehensive, well coordinated, quality care that is evidence-based + comparable

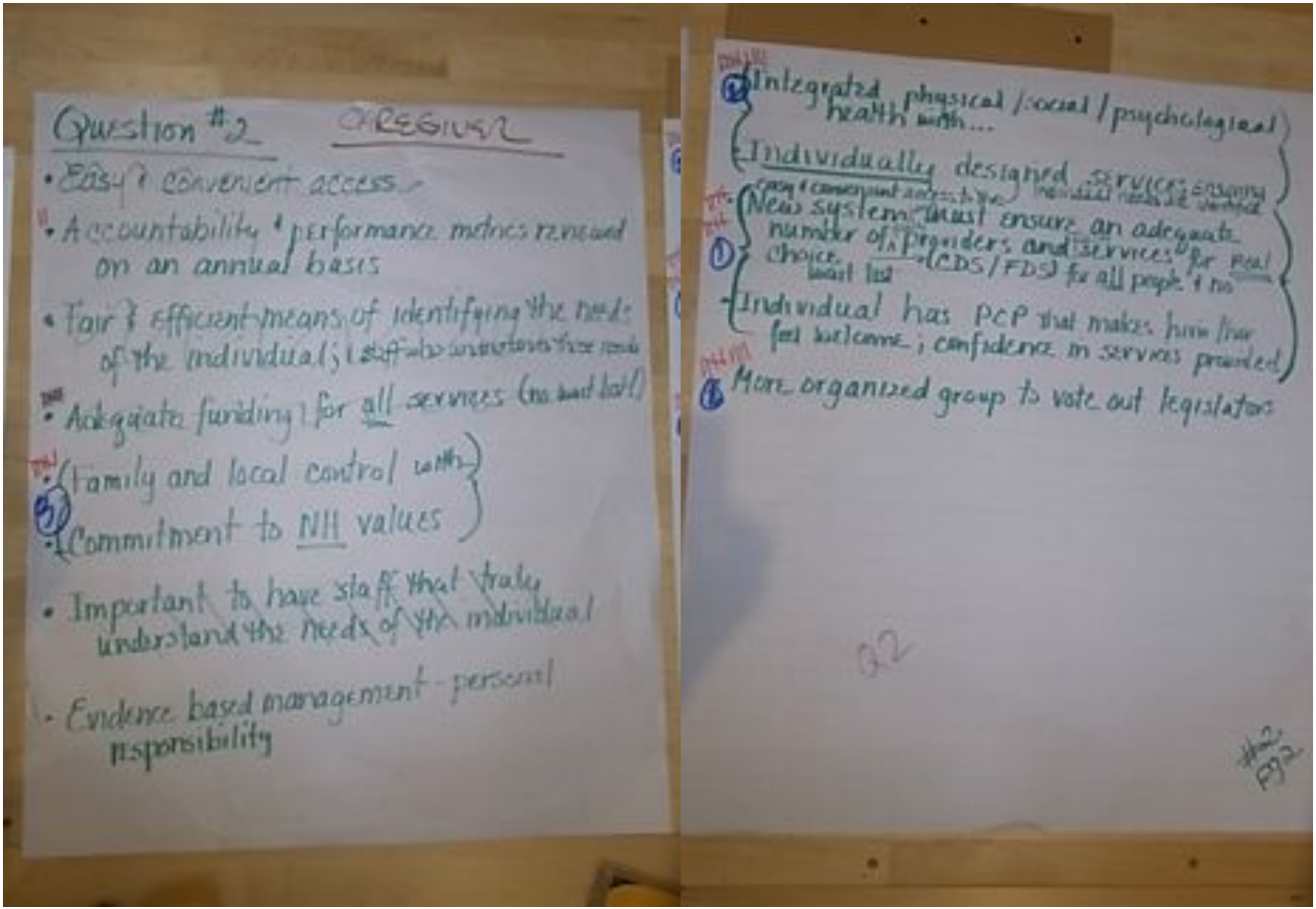

Exercise 1 Recipient BC 10/5/5 35-C-10c
• Support for Daily Living Skills
1 • Reliability of Provider Service + treatment
• Consistency of Provider
• Barriers minimized to / or home
8 free access to community based individualized care
• timely access to responsive providers
• individual choice (consumer directed model we have today)
better effective information on health care choices and services
effective communication between providers

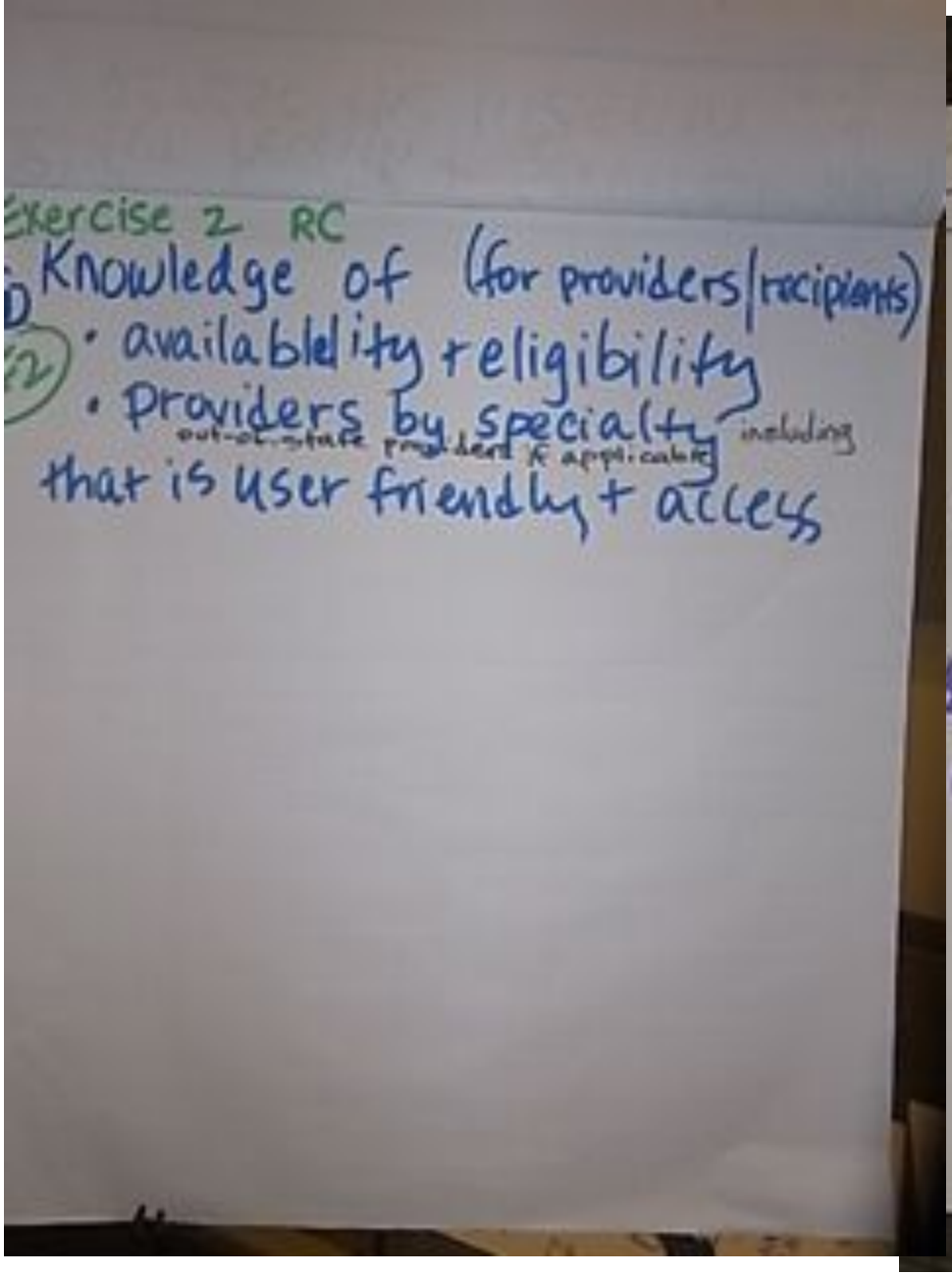

Exercise #1 Recipient
whole person perspective for health + service (including ADL) across the lifespan
activities of Daily Living
Exercise is an important part of daily Living

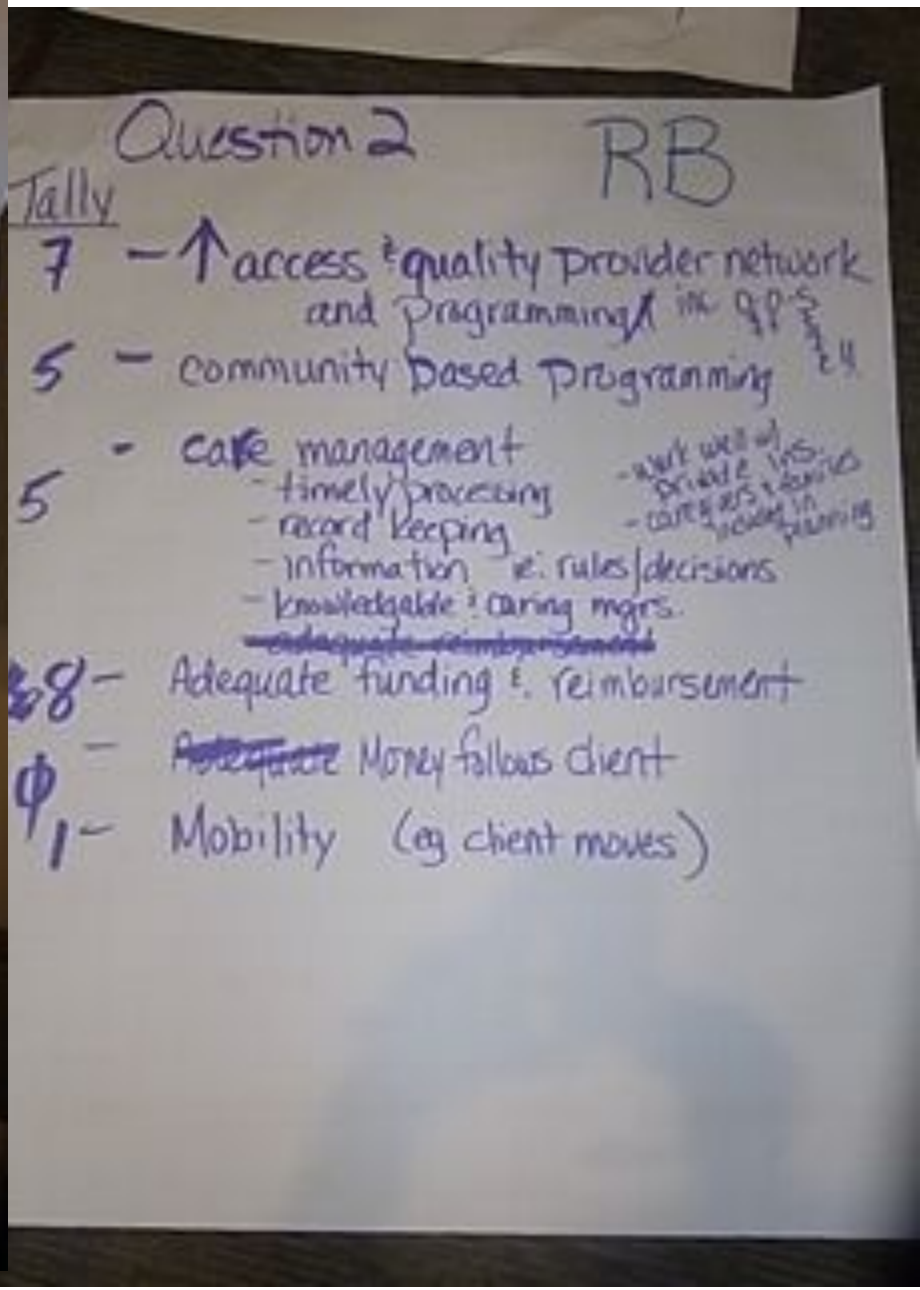

RECIPIENTS CAREGIVER
QUESTION #1
R1
Access to right care & right time ... and not get what they do not need
Integration of social & medical care leading to independence
Choice - choosing own doctor/services/ → determining where you want to go when you want to go
Absence of red tape
Maintenace of health & freedom to be [active] in the community (to be active in community) to be as independent as possible
Access to same healthcare & dental care as every other citizen
Everyone should get what they need ... and not get what they don't need

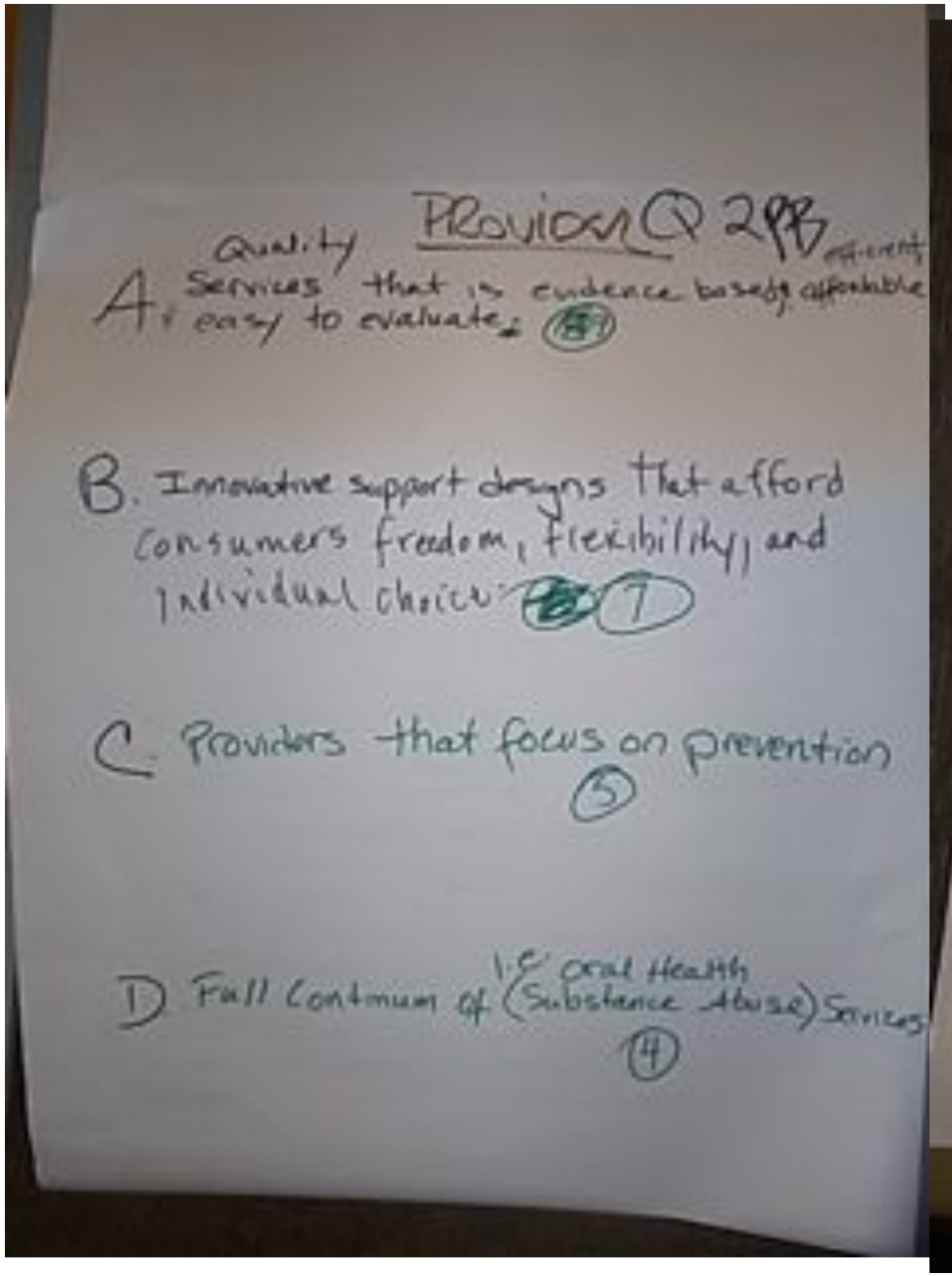

#1
R1
pg 2
having the same opportunities as everyone else
Easy access to medical professionals & hospitals
Individualized community supports directed by families
Having a broad range of services available
The best health possible
Medical personnel on premises (not LPNs)
Provide continuity before-during-after system change (medical professionals serving consumer)
Local control
pg2

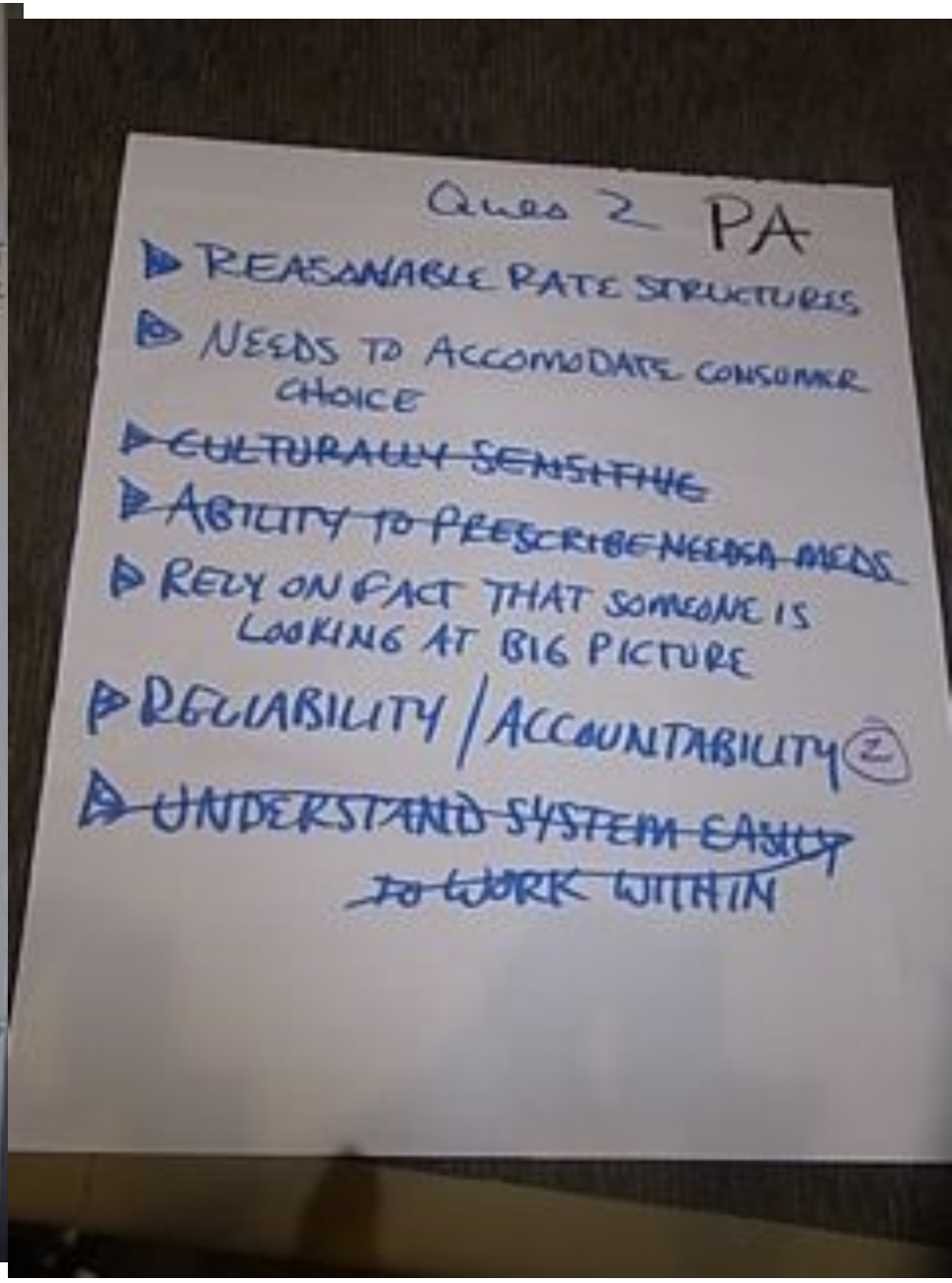

Quest #1 (RB)
Tally
7 Respect - no bias, indistinguishable from non Medicaid citizens, personal satisfaction
7 Quality opportunities - day program - socialization - recreation - employment
4 Choice - full range sizes
3 ease of enrollment - & hassle, options
3 Meeting unique individual needs of given populations
1 Safety, security, adaptability
Question 2 RB
Ques 1 PA
EFFECTIVENESS
QUALITY
INTEGRATION & SERVICES - INDIVIDUALIZED HOLISTIC / COMPREHENSIVE 2
FREE & CONFLICT & INTEREST 1
SERVICES STIGMA-FREE/MAINTAIN DIGNITY 1
ATTENTIVE / LISTENING
GOOD FOLLOW-UP

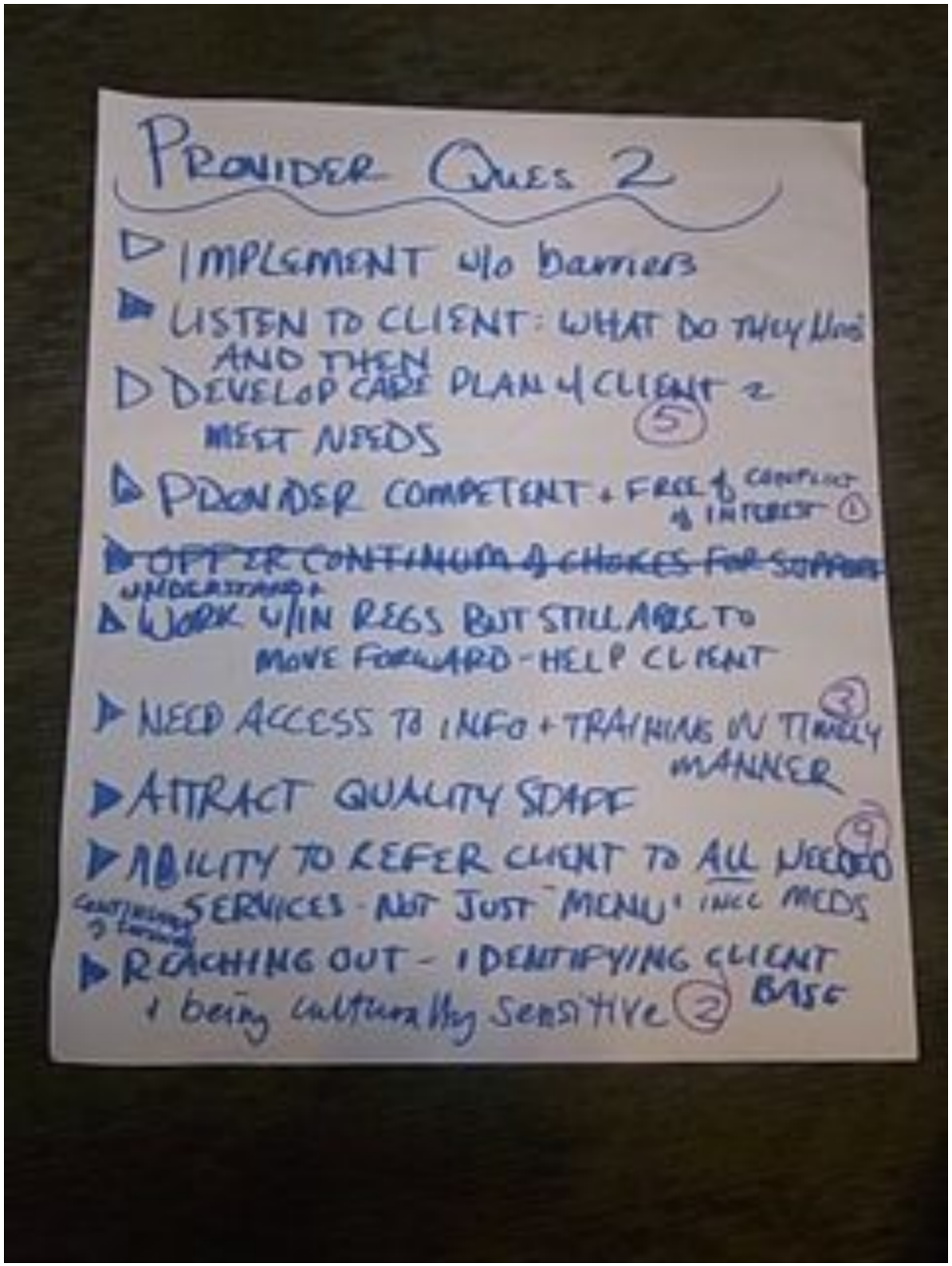

Question #2 CAREGIVER
• Easy & convenient access
• Accountability & performance metrics reviewed on an annual basis
• Fair & efficient means of identifying the needs of the individual;
• Adequate funding for all services
• Family and local control with
• Commitment to NH values
• Important to have staff that truly understand the needs of the individual
• Evidence based management - personal responsibility
Integrated physical / social / psychological health with...
Individually designed services ensuring
New system must ensure an adequate number of providers and services for real choice.
(CDS / FDS) for all people & no wait list
Individual has PCP that makes him/her feel welcome; confidence in services provided
More organized group to vote out legislators

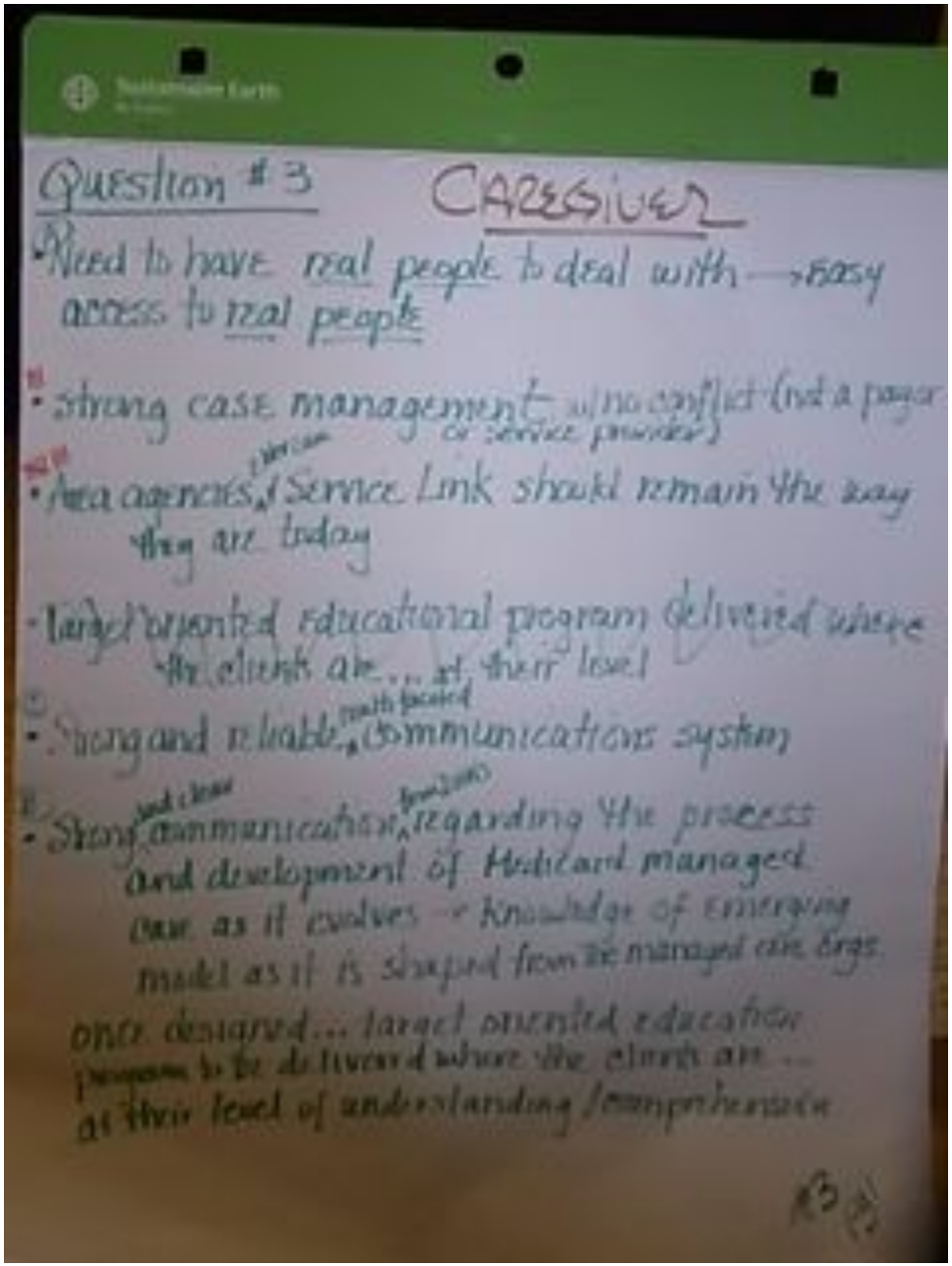

Exercise 2 RC
Knowledge of (for providers/recipients)
• availabledity + eligibility
• Providers by specialty including
out-of-state resident if applicable
that is user friendly + access


Question 2
RB
Tally
7 – ↑ access & quality Provider network and Programming in 9P's
5 – community based Programming
5 – care management
- timely processing
- record keeping
- information ie. rules/decisions
- knowledgable & caring mgrs.
~~adequate reimbursement~~
8 – Adequate funding & reimbursement
– ~~Adequate~~ Money follows client
1 – Mobility (eg client moves)


PROVIDERS
A. Quality Services that is evidence based, affordable, efficient & easy to evaluate; (1)
B. Innovative support designs that afford consumers freedom, flexibility, and individual choice; (6) (7)
C. Providers that focus on prevention (5)
D. Full Continum of I.E. Oral Health (Substance Abuse) Services (4)

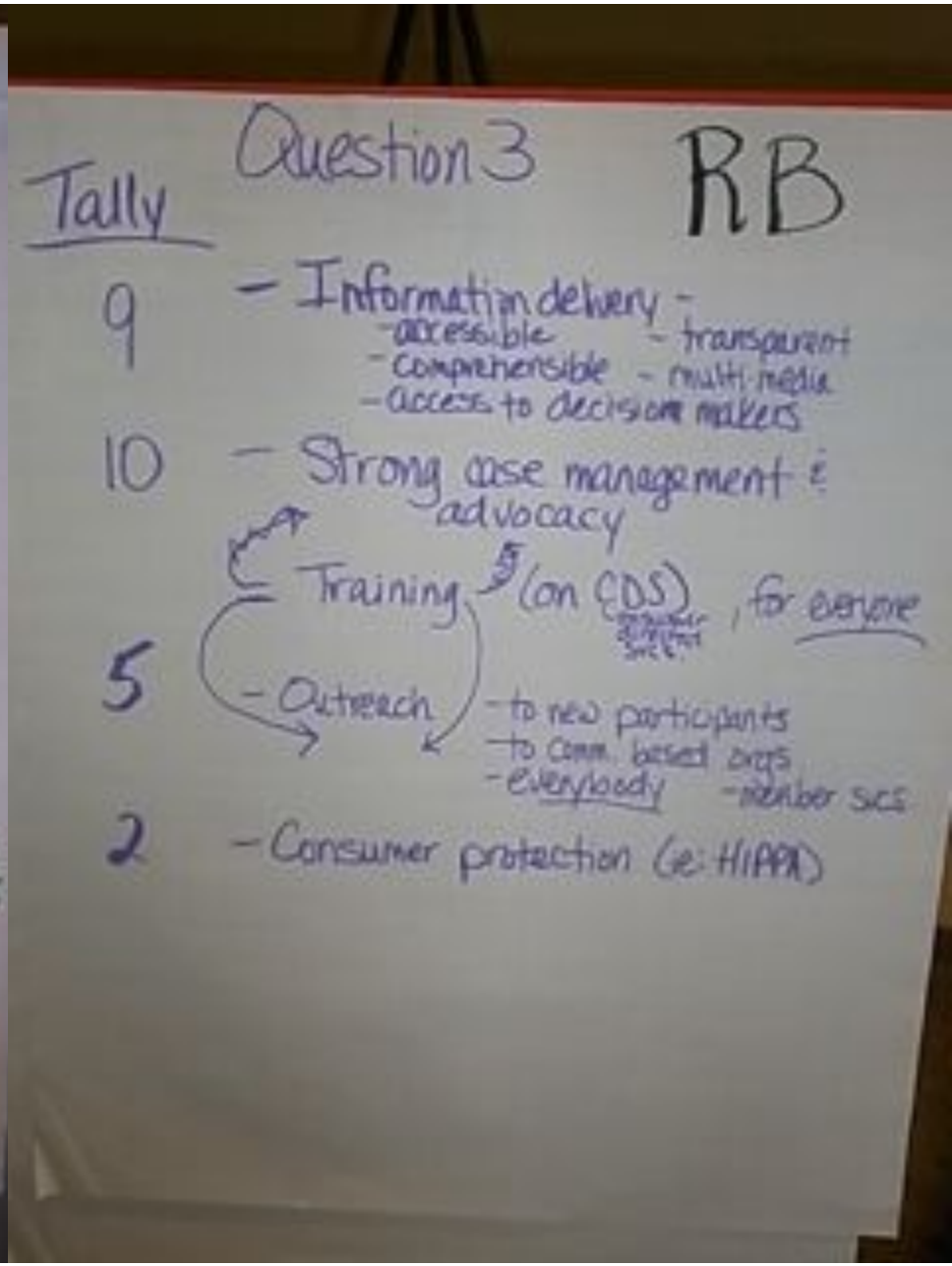

Ques 2 PA
REASONABLE RATE STRUCTURES
NEEDS TO ACCOMODATE CONSUMER CHOICE
CULTURALLY SENSITIVE
ABILITY TO PRESCRIBE NEEDS BASED NEEDS
RELY ON FACT THAT SOMEONE IS LOOKING AT BIG PICTURE
RELIABILITY / ACCOUNTABILITY (2)
UNDERSTAND SYSTEM EASILY TO WORK WITHIN

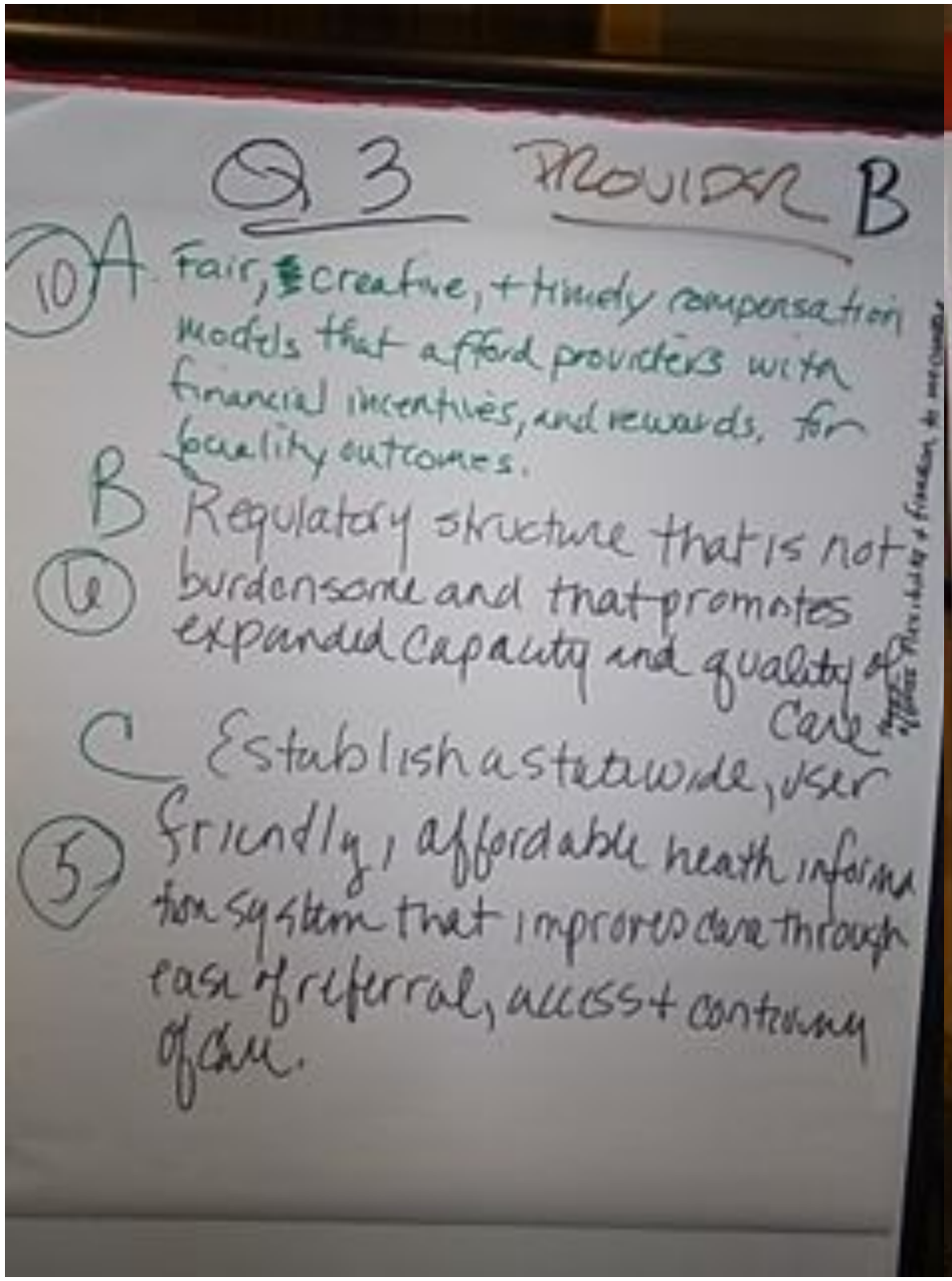

PROVIDER QUES 2
IMPLEMENT w/o barriers
LISTEN TO CLIENT: WHAT DO THEY NEED
AND THEN
DEVELOP CARE PLAN w/ CLIENT to
MEET NEEDS
5
PROVIDER COMPETENT + FREE of CONFLICT of INTEREST 1
OFFER CONTINUUM of CHOICES FOR SUPPORT
UNDERSTAND +
WORK w/IN REGS BUT STILL ABLE TO
MOVE FORWARD - HELP CLIENT
NEED ACCESS TO INFO + TRAINING IN TIMELY MANNER 3
ATTRACT QUALITY STAFF
ABILITY TO REFER CLIENT TO ALL NEEDED 9
SERVICES - NOT JUST "MENU" INCL MEDS
REACHING OUT - IDENTIFYING CLIENT BASE
+ being culturally SENSITIVE 2

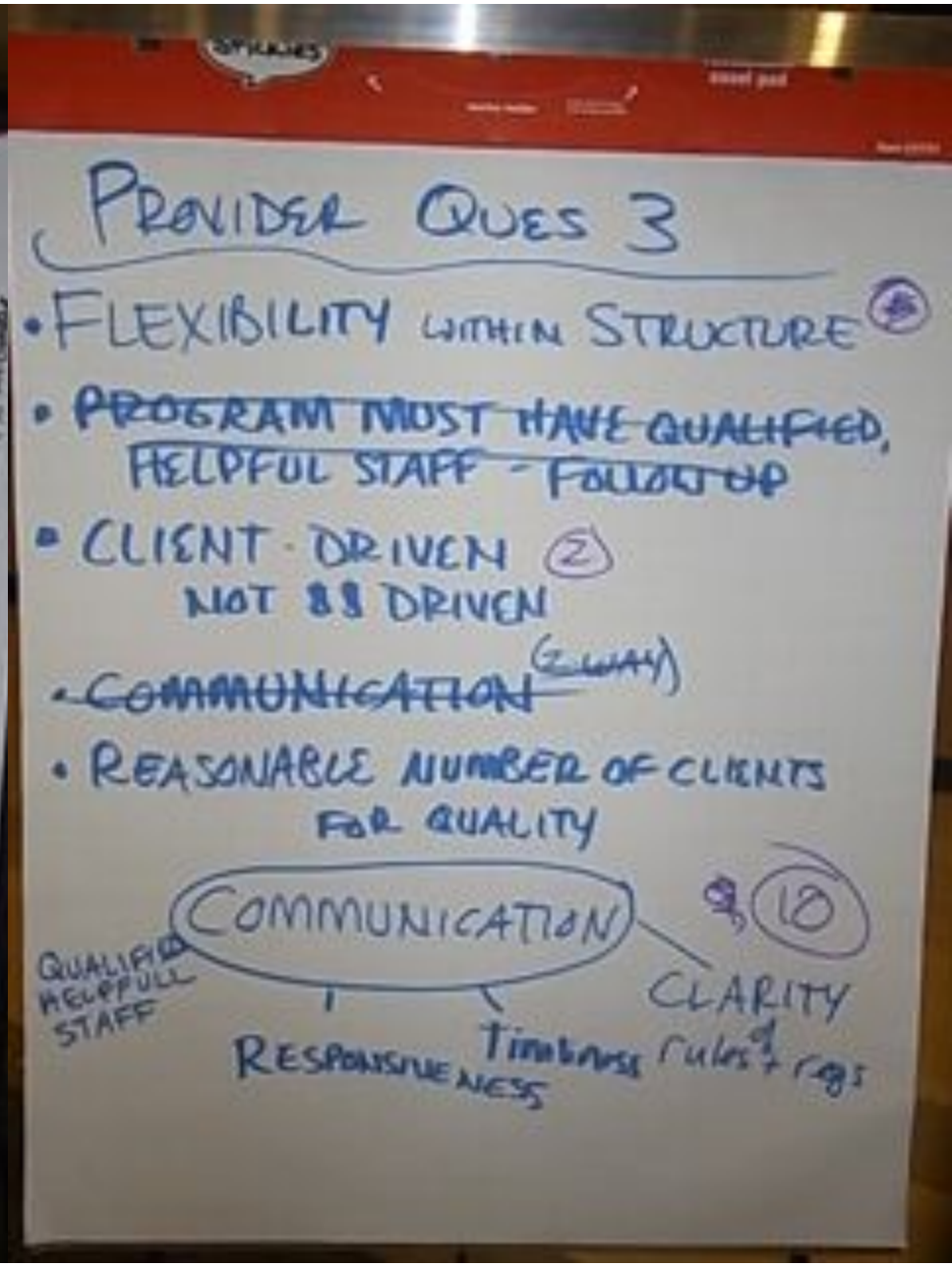

Question # 3
CAREGIVER
Need to have real people to deal with → easy access to real people
strong case management w/ no conflict (not a payor or service provider)
Area agencies, Service Link should remain the way they are today
Target oriented educational program delivered where the clients are... at their level
Strong and reliable, multi faceted communications system
Strong communication regarding the process and development of Medicaid managed care as it evolves - Knowledge of emerging model as it is shaped from the managed care orgs.
once designed... target oriented education program to be delivered where the clients are... at their level of understanding/comprehension
#3

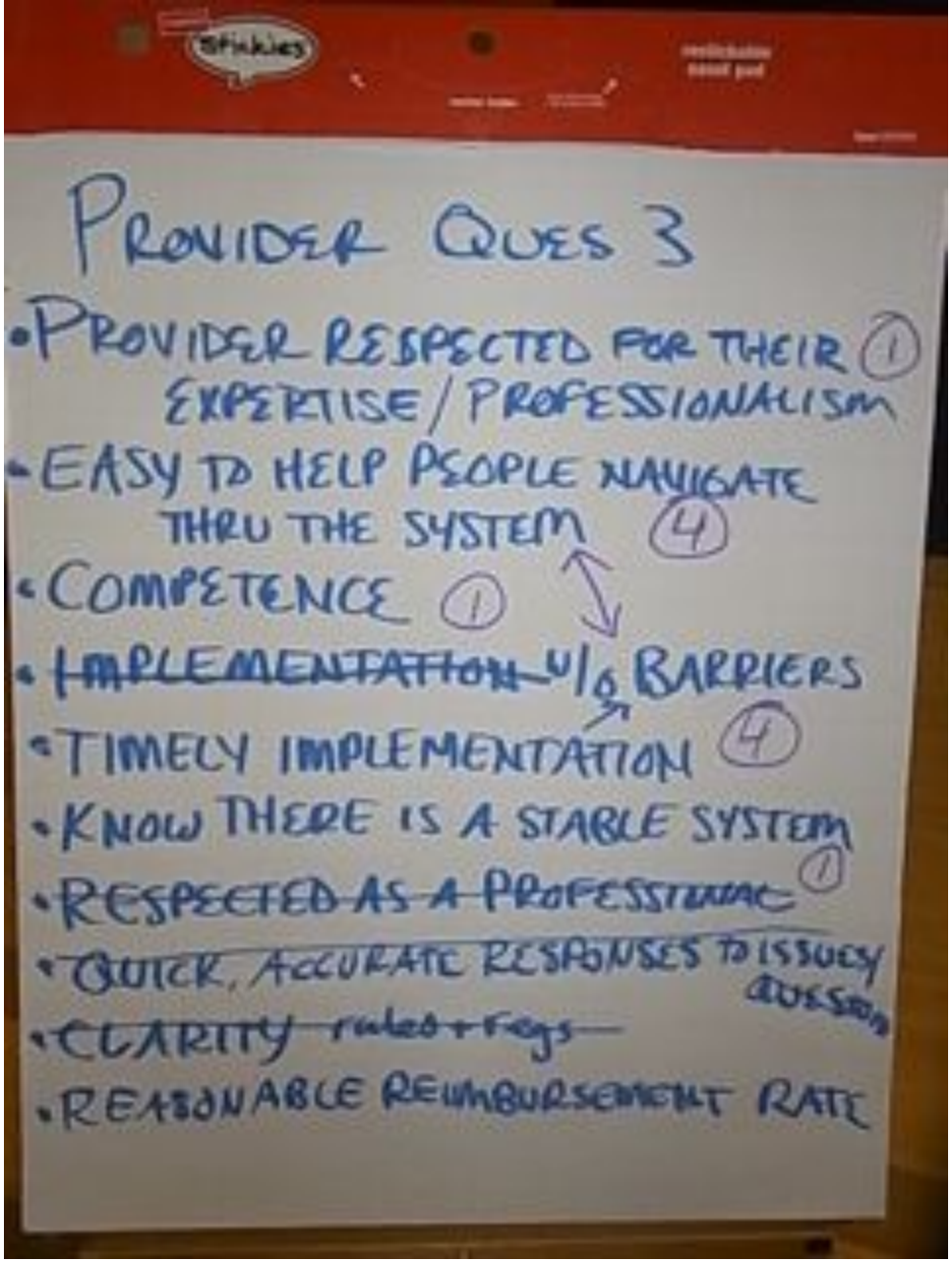

Multi faceted way of accessing information
Good communication
A
B
C
D


Exercise 3
RC
#4
System can not be overly complicated and must be both individualized and unified and must include
#2
Information infrastructure accessible by first responders and provided to consumers at first contact
#3
Community based way to disseminate information — including use of volunteers
→ to individuals who don't speak English
→ Innovation Services driven by families and consumers


Question 3
RB
Tally
9 – Information delivery –
- accessible
- transparent
- comprehensible
- multi media
- access to decision makers
10 – Strong case management & advocacy
Training (on CDS), for everyone
5 – Outreach
- to new participants
- to comm. based orgs
- everybody
- member svcs
2 – Consumer protection (ie: HIPPA)


Q 3 PROVIDER B
10 A Fair, creative, + timely compensation models that afford providers with financial incentives, and rewards, for quality outcomes.
B Regulatory structure that is not burdensome and that promotes expanded capacity and quality of Care
C Establish a statewide, user friendly, affordable health information system that improves care through ease of referral, access + continuity of Care.
5


PROVIDER QUES 3
• FLEXIBILITY WITHIN STRUCTURE 4
• PROGRAM MUST HAVE QUALIFIED, HELPFUL STAFF - FOLLOW UP
• CLIENT - DRIVEN 2
NOT $$ DRIVEN
• COMMUNICATION (& WAY)
• REASONABLE NUMBER OF CLIENTS FOR QUALITY
COMMUNICATION 9, 10
QUALIFIED HELPFULL STAFF
RESPONSIVENESS
Timeliness
CLARITY rules + regs


PROVIDER QUES 3
• PROVIDER RESPECTED FOR THEIR EXPERTISE/PROFESSIONALISM (1)
• EASY TO HELP PEOPLE NAVIGATE THRU THE SYSTEM (4)
• COMPETENCE (1)
• IMPLEMENTATION W/O BARRIERS
• TIMELY IMPLEMENTATION (4)
• KNOW THERE IS A STABLE SYSTEM
• RESPECTED AS A PROFESSIONAL (1)
• QUICK, ACCURATE RESPONSES TO ISSUES
• CLARITY
• REASONABLE REIMBURSEMENT RATE

NH Medicaid
Care Management Program
Public Forum

North Country, NH

September 21, 2011

Disclaimer

Please note that the comments and priorities that follow reflect the opinions of participating workgroups and not necessarily those of the Department of Health and Human Services.

Photos of charts reflect workgroup work process and product. Items crossed out typically reflect brainstormed suggestions that were combined with others.

Note: In this Forum the first exercise was skipped and the definition of Quality of Life was used from the first two forums. We have documented them as Exercises 1 and 2, while the flip charts may be labeled Exercises 2 and 3.

Program User Perspective - Exercise 1

What's needed to increase # with high quality of life/health?

- Access to care: right care at the right time including transportation with follow up
- Consumers need to feel empowerment and have choice, Care needs to be individualized.
- Integration of services is very important
  - Noticing that people are people not patients or numbers
  - Coordination of providers
  - Talking to people at the right level
  - Community based services
- Consistency
  - A lot of time spent manipulating the system to get what their children need.
  - Big fear that all of the providers will vanish and they will have to start over
- Money
  - The system is already constrained by money. Adding another layer is sucking more money out of the system and giving it to other people
  - Want to make sure decisions are made by PROFESSIONALS NOT BEAN COUNTERS

Provider Perspective – Exercise 1

What's needed to increase # with high quality of life/health

- Fair pay
- For chronic people, want to get payment even if there is no progression.
- Access to services and transportation especially in the North Country (limited reimbursement)
- Must be able to refer services that are needed, and know if they are covered
- System of comprehensive and integrated services for home based and community based care. Individuals get what they need for special needs
- Access to local community based services at point of need in timely manner, ESPECIALLY IN NORTH COUNTRY
- Access to transportation – too many people can't get to hospital or appointment
- Access to care is an issue especially with geographic distances in North Country with limited transportation and expense of providing services
- An advocate for patients to navigate the managed care system and their options. Must be communicated in a very simplistic way so they can understand
- Providing very comprehensive services geared to prevention. Medical home with care for the whole body (physical, social, emotional, economic factors)

Program User Perspective – Exercise 2

In a care management program, what must happen in order to create **knowledgeable and informed** recipients?

- Good communication with education giving clear guidelines so clients and caregivers (and their families) can understand
- Fear that providers will go out of business or lose jobs and affect continuity of care
- Fair reimbursement
- Overwhelmingly concerned with INCLUSION and LISTENING
  - Clients involvement in all decision making at the appropriate level
  - Never saying we've decided what is best for you and this is what it is
  - Listen to individual with respect
- Important aspects of support that agencies use to ensure the clients have a better life
  - Peer group
  - Child care
  - Safe housing

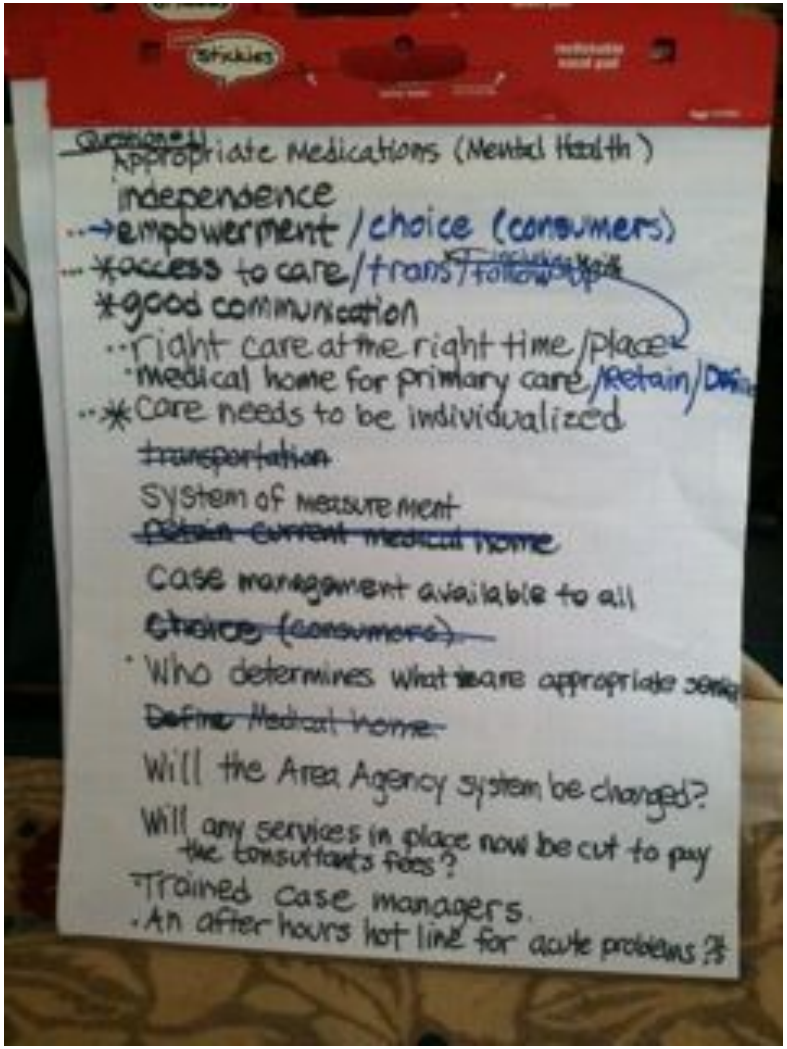
Provider Perspective – Exercise 2

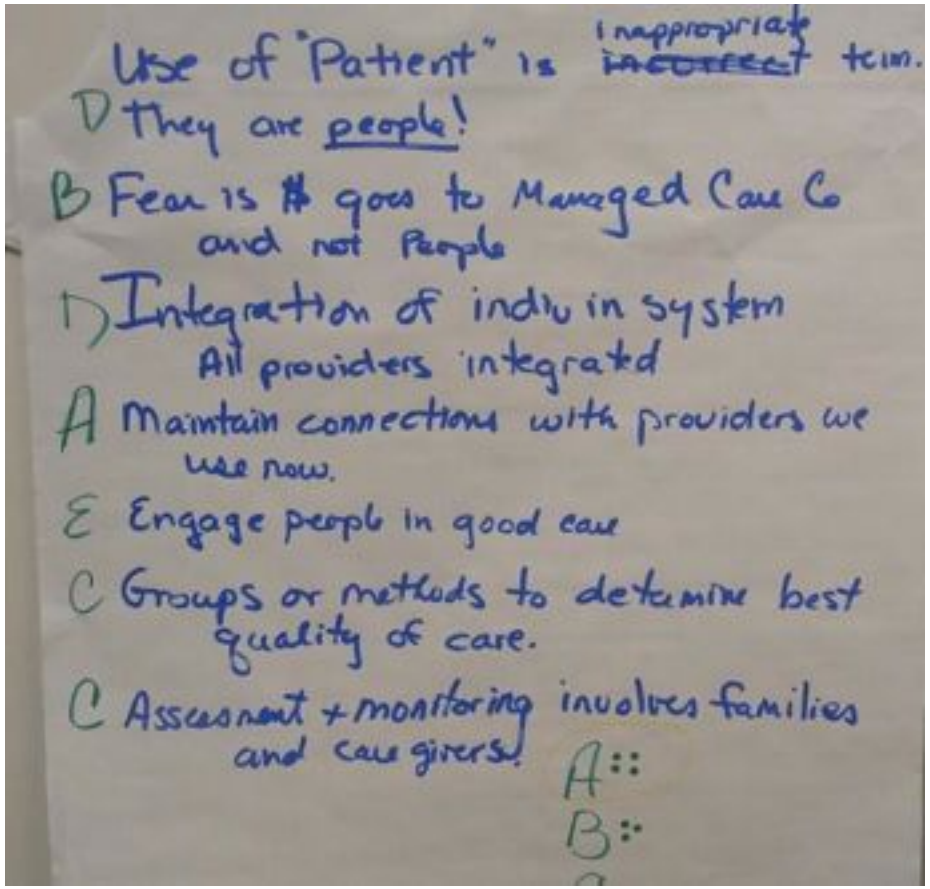
In a care management program, what must happen in order to **create satisfied providers** instead of dissatisfied (or **Resistant**) providers?

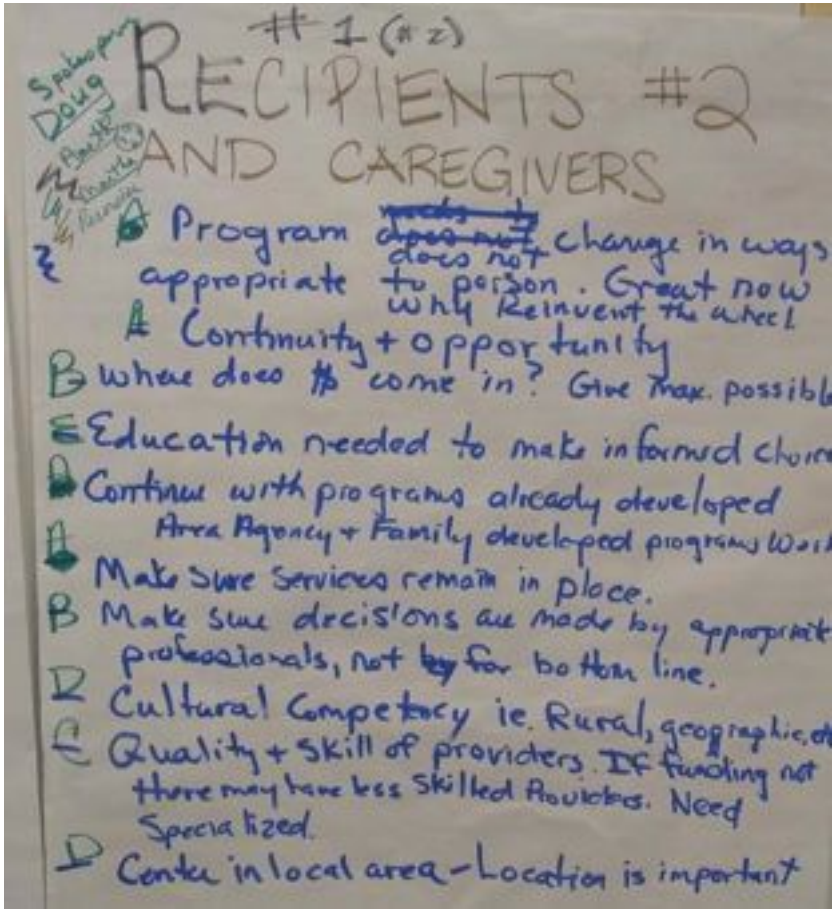
- Trust that doctors know what care is needed.
- Similar guidelines for what outcomes are.
- We need to have information on the Affordable Care Act before implemented so that we can tell clients what we can do
- Coordinating training for the service agencies so that we can tell people what services they can get, how to access, and how much they can get.
- Expectation for providers should be consistent but allow flexibility without penalties
- Reimbursement adequate, reasonable, timely, and predictable
- Streamlined reporting documentation requirements so everyone is on same page
- A very fair reasonable system where reimbursement is perceived as adequate and is adjusted because very few providers in the North Country will accept it which means those who do are VERY OVERLOADED.
- Fairness and equality helping people navigate through with a seamless coordinated approach that is electronic/internet based. Coordination between physicians for an individual.
- Medical home approach: offering a very holistic care plan to the individual and protecting their rights and providing access to coordinated services

Program User Perspective - Exercise 1

What's needed to increase # with high quality of life/health?

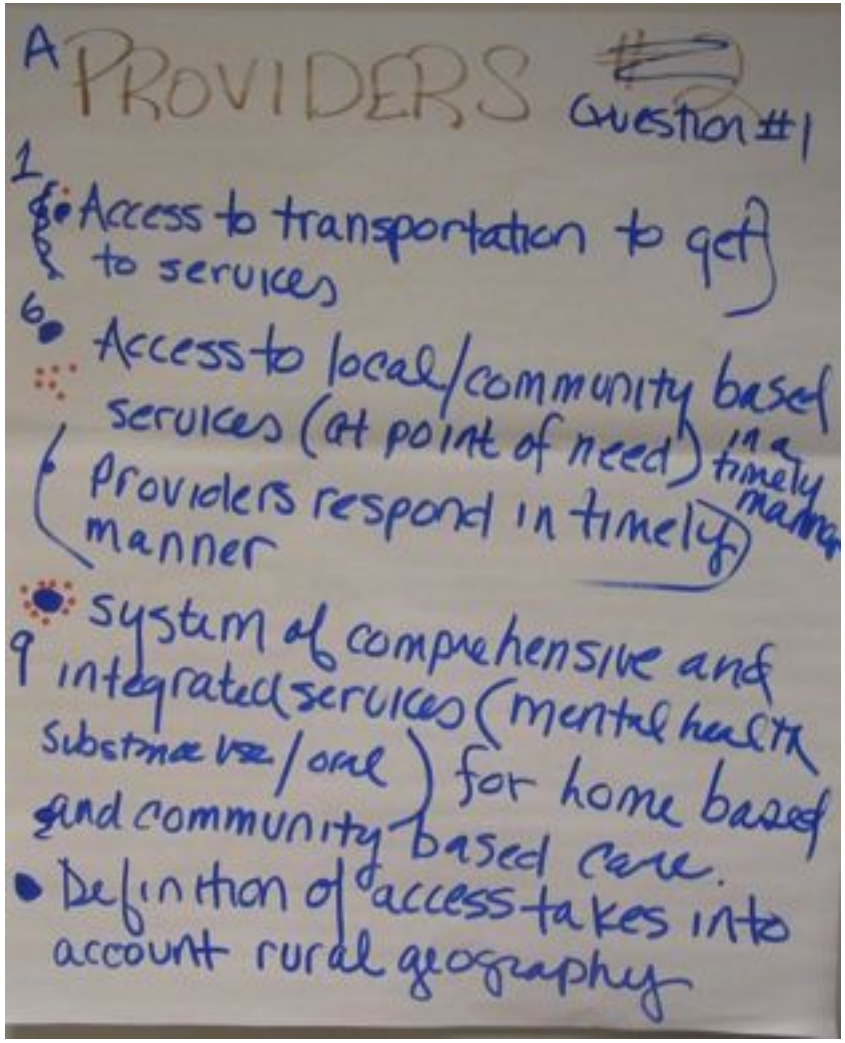


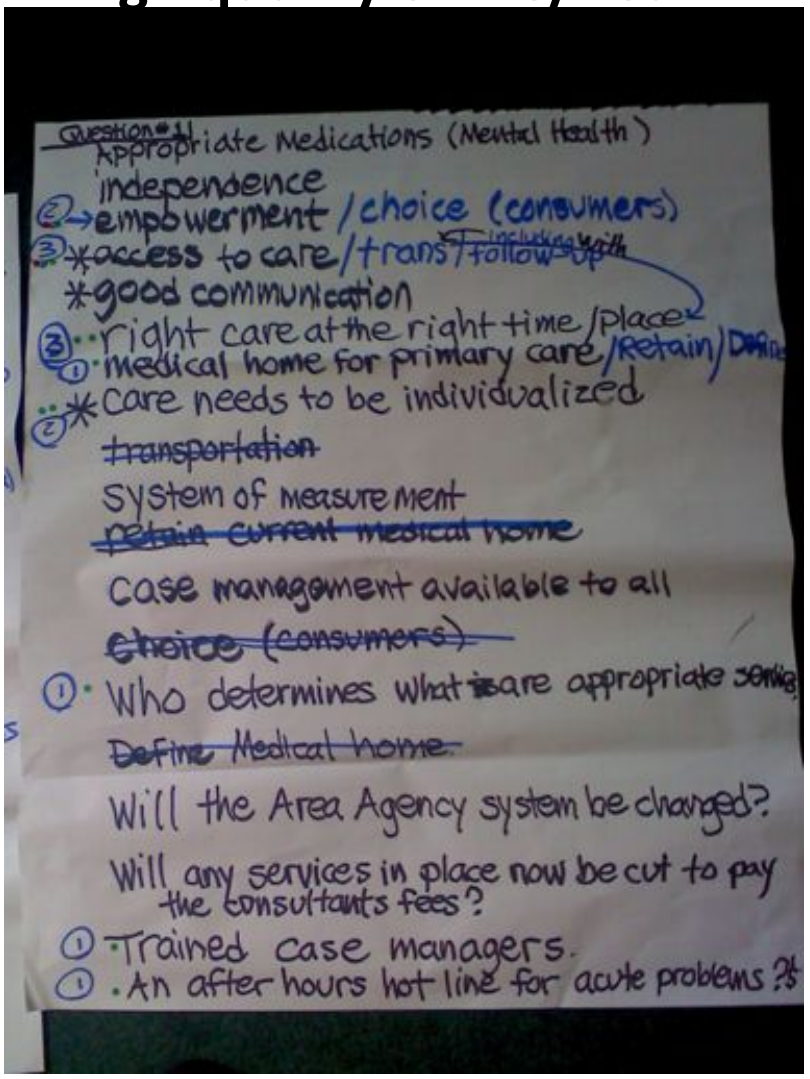

Use of "Patient" is inappropriate term.
D They are people!
B Fear is $ goes to Managed Care Co and not People
D Integration of indiv in system
All providers integrated
A Maintain connections with providers we use now.
E Engage people in good care
C Groups or methods to determine best quality of care.
C Assessment + monitoring involves families and care givers!
A::
B::

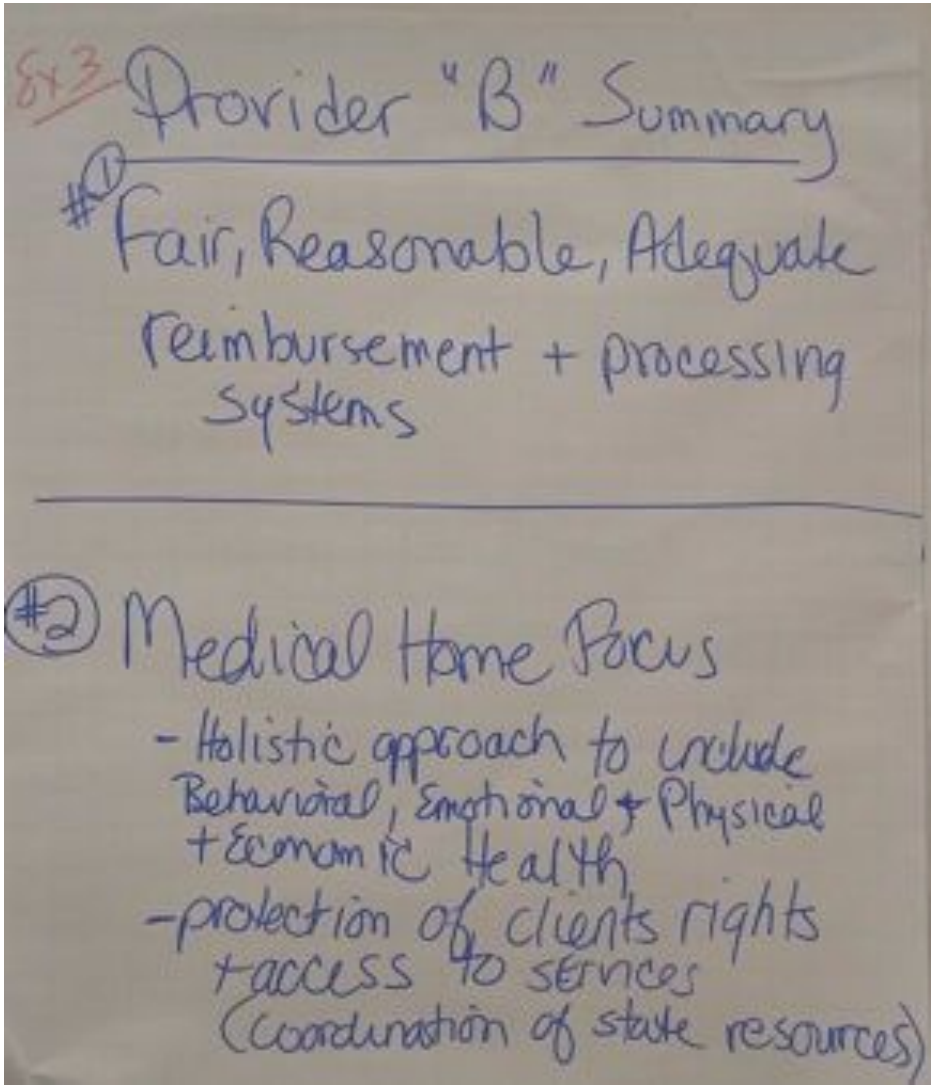

#1 (#2)
RECIPIENTS #2
AND CAREGIVERS
Program does not change in ways appropriate to person. Great now why Reinvent the wheel
A Continuity + opportunity
B Where does $ come in? Give max. possibl
E Education needed to make informed choic
Continue with programs already developed
Area Agency + Family developed programs work
Make sure services remain in place.
B Make sure decisions are made by appropriate professionals, not by for bottom line.
R Cultural Competency ie. Rural, geographic
E Quality + skill of providers. If funding not there may have less skilled Providers. Need Specialized.
D Center in local area - Location is important

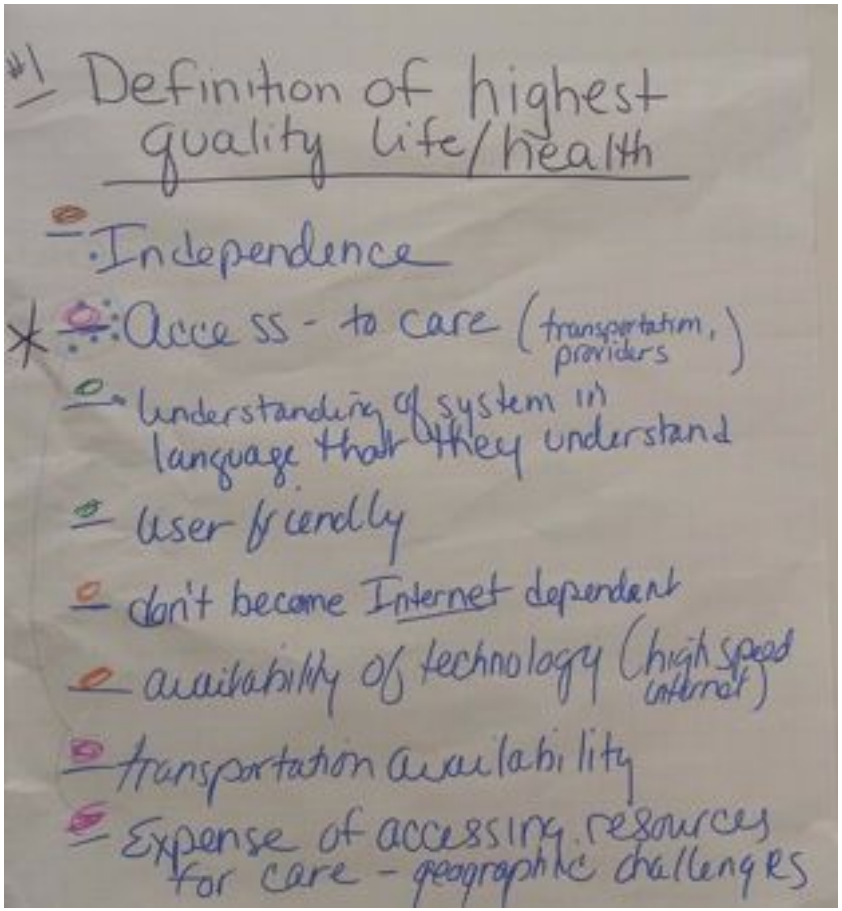
Provider Perspective – Exercise 1

What's needed to increase # with high quality of life/health



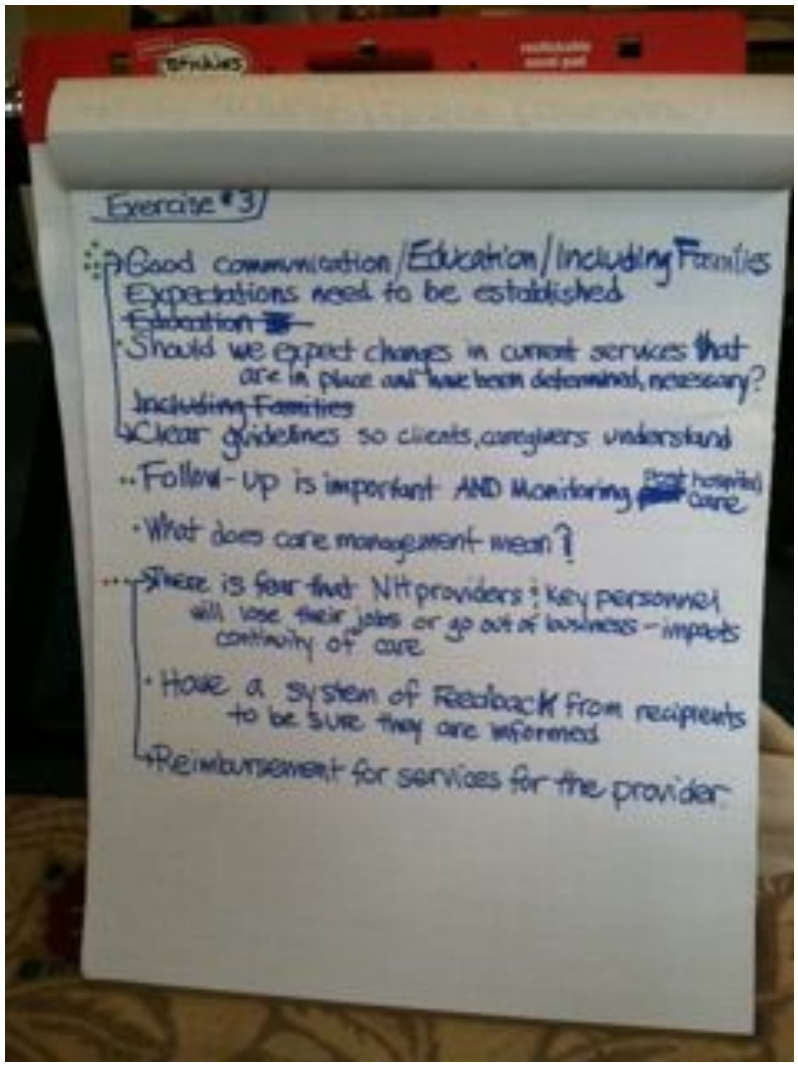


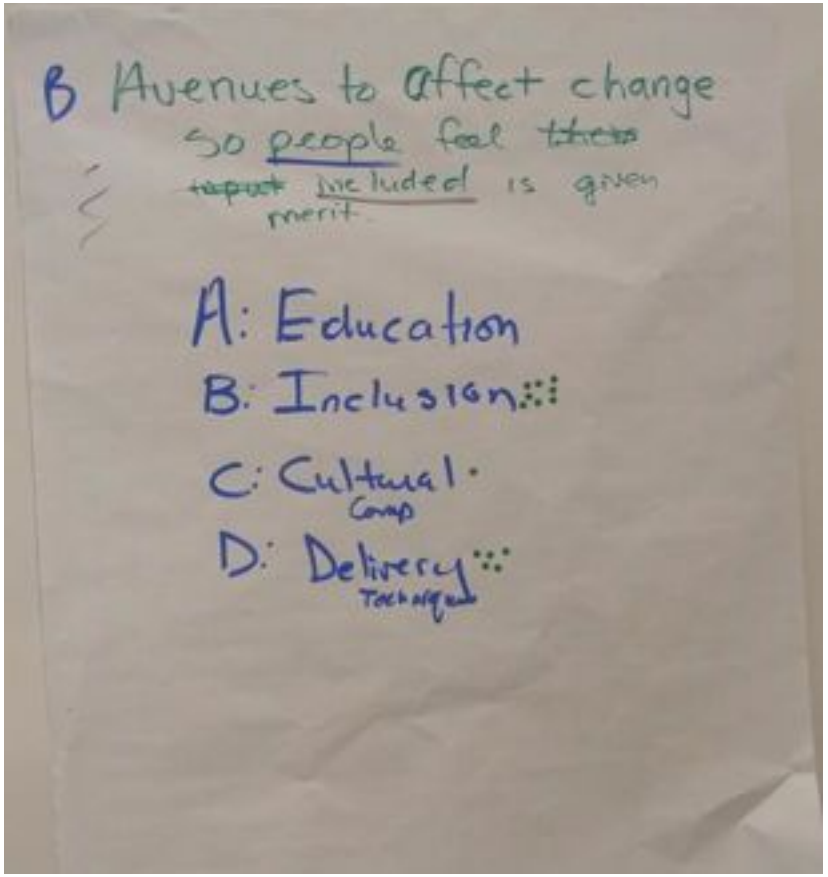

8x3
Provider "B" Summary
#1
Fair, Reasonable, Adequate
reimbursement + processing
systems
#2
Medical Home Focus
- Holistic approach to include
Behavioral, Emotional + Physical
+ Economic Health
- protection of clients rights
+ access to services
(coordination of state resources)

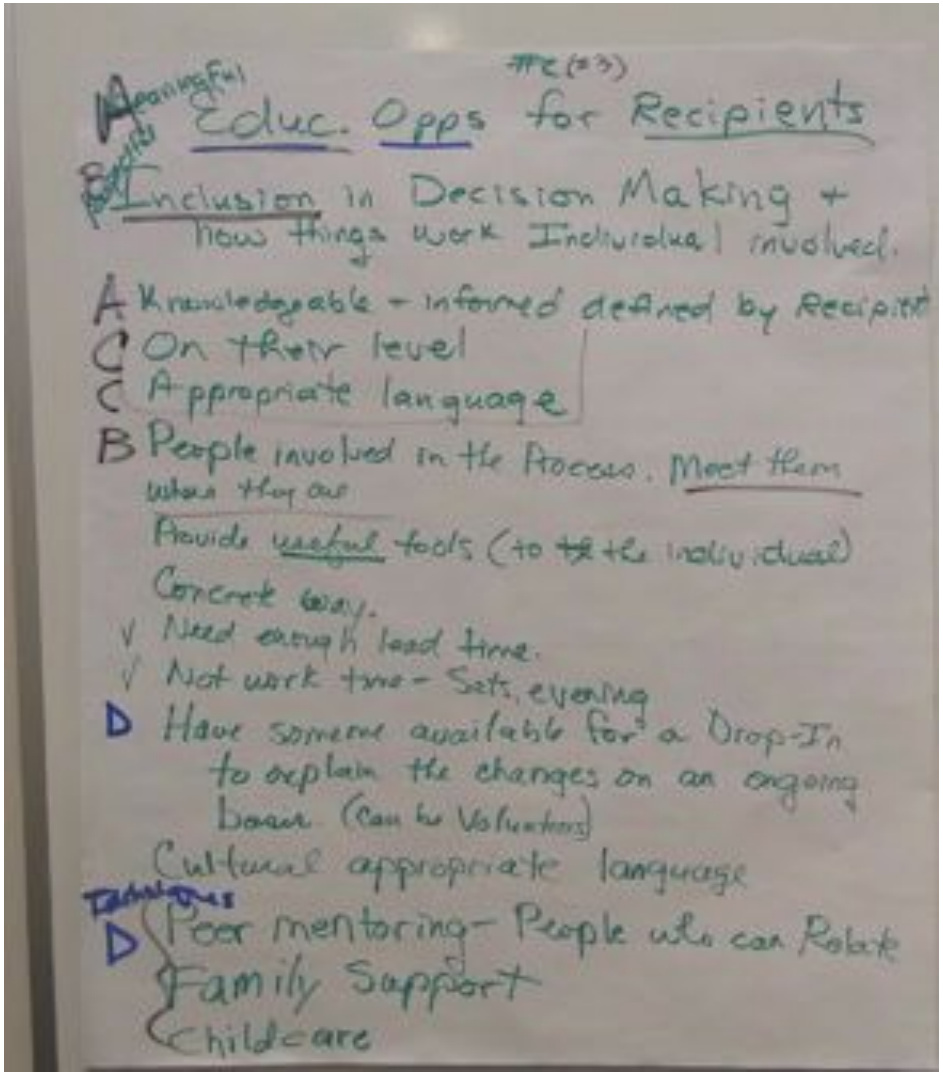

#1
Definition of highest
quality life/health
Independence
Access - to care (transportation, providers)
understanding of system in
language that they understand
user friendly
don't become Internet dependent
availability of technology (high speed internet)
transportation availability
Expense of accessing resources
for care - geographic challenges

Program User Perspective – Exercise 2

In a care management program, what must happen in order to create **knowledgeable and informed** recipients?

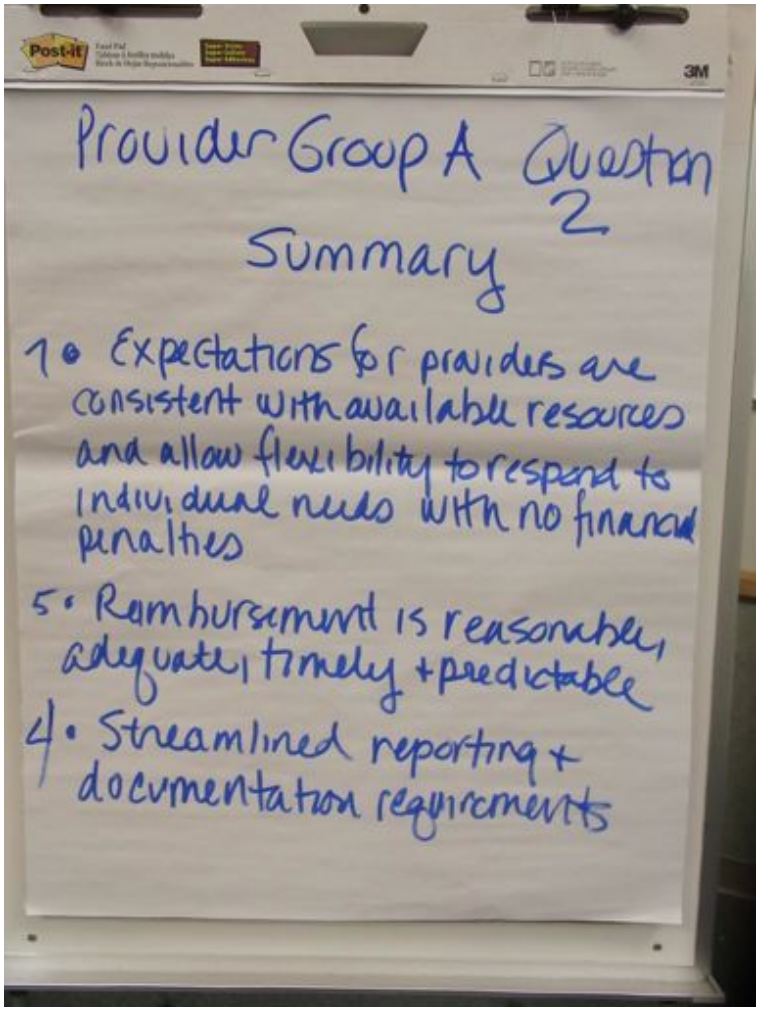


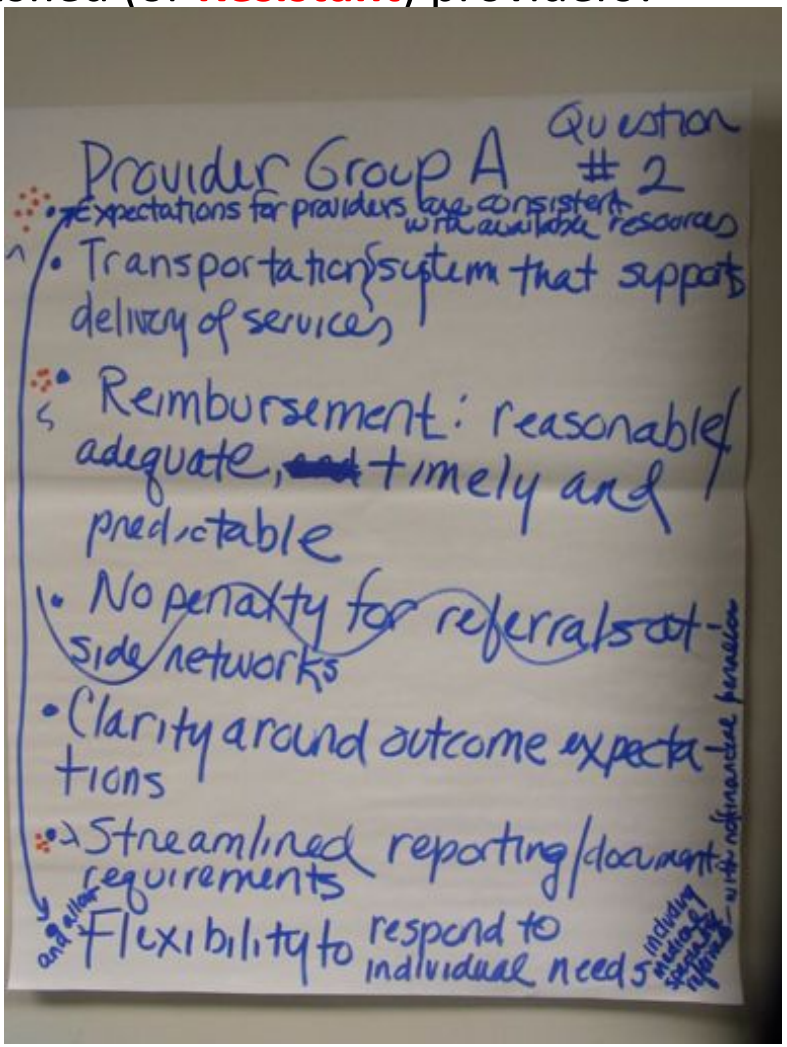

B Avenues to affect change
so people feel ~~their~~ ~~report~~ included is given merit.
A: Education
B: Inclusion
C: Cultural
Comp
D: Delivery
Technical

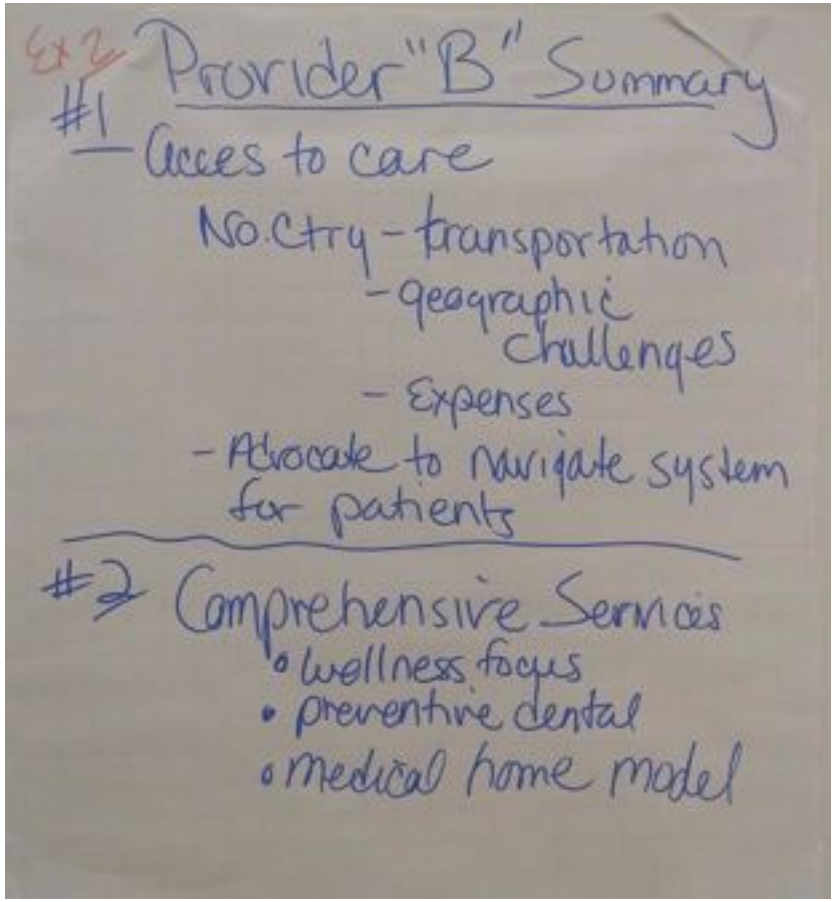

Educ. Opps for Recipients
Inclusion in Decision Making + how things work Individual involved.
A Knowledgeable - informed defined by Recipient
C On their level
C Appropriate language
B People involved in the Process. Meet them where they are
Provide useful tools (to the individual)
Concrete way.
√ Need enough lead time.
√ Not work time - Sats, evening
D Have someone available for a Drop-In to explain the changes on an ongoing basis (can be Volunteers)
Cultural appropriate language
D Peer mentoring - People who can Relate
Family Support
Childcare

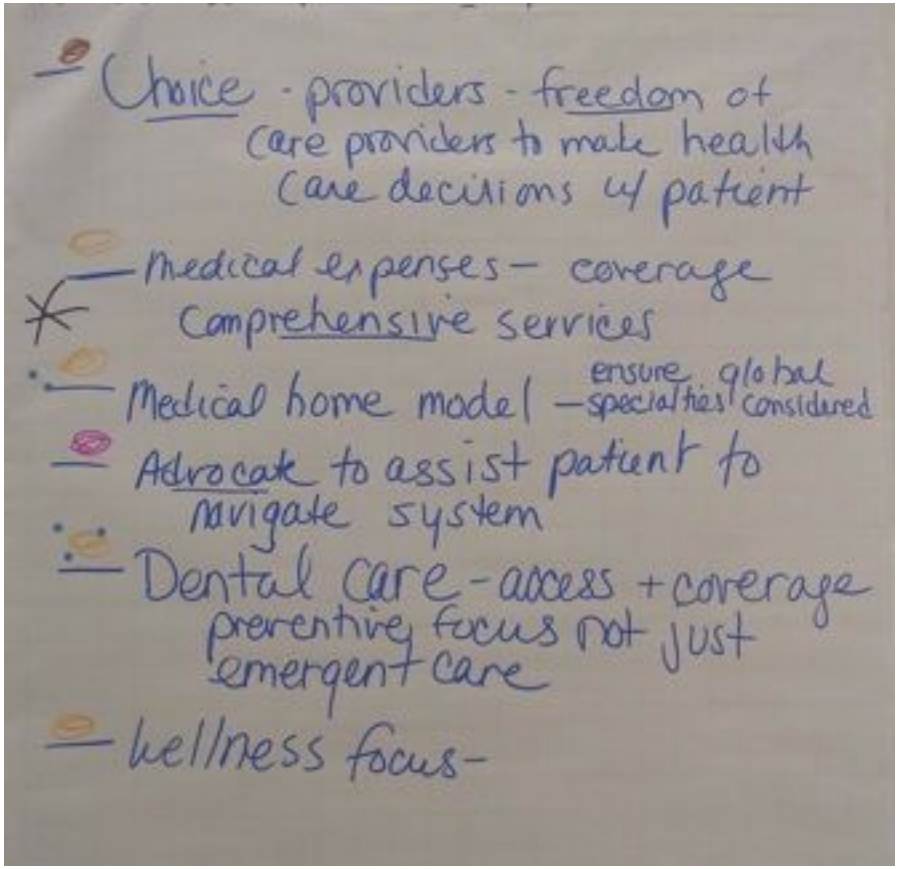
Provider Perspective – Exercise 2

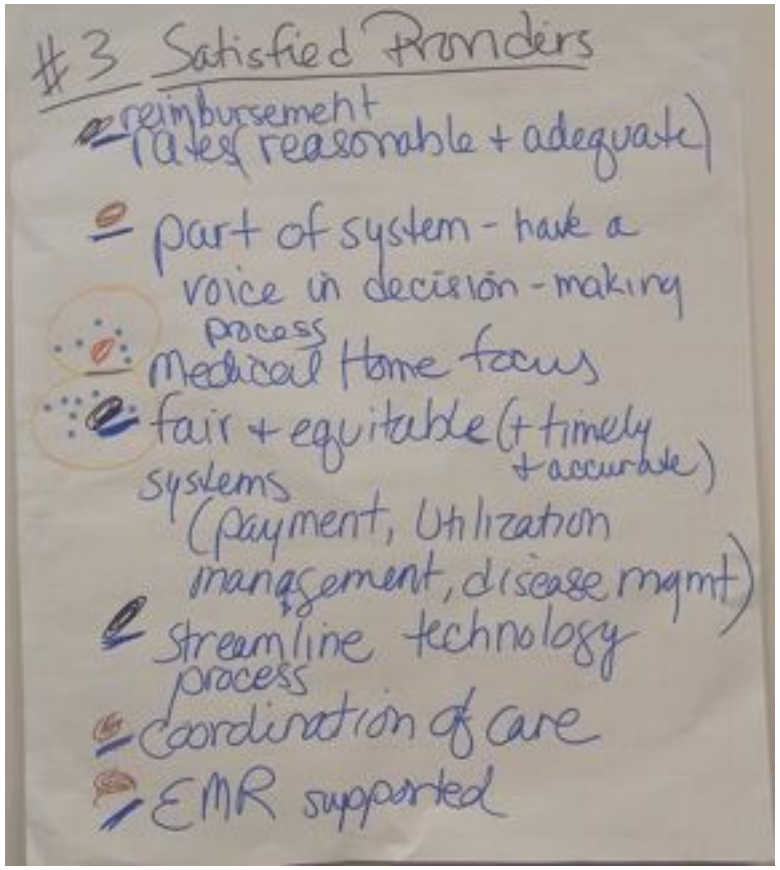
In a care management program, what must happen in order to **create satisfied providers** instead of dissatisfied (or **Resistant**) providers?

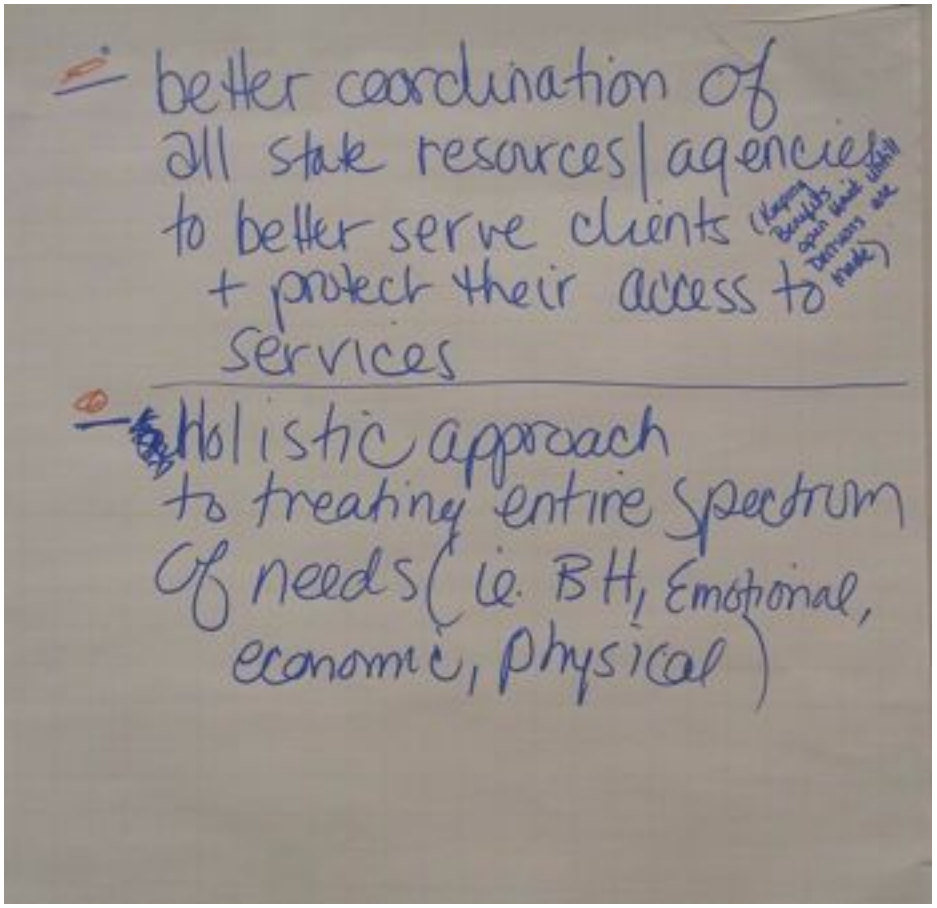


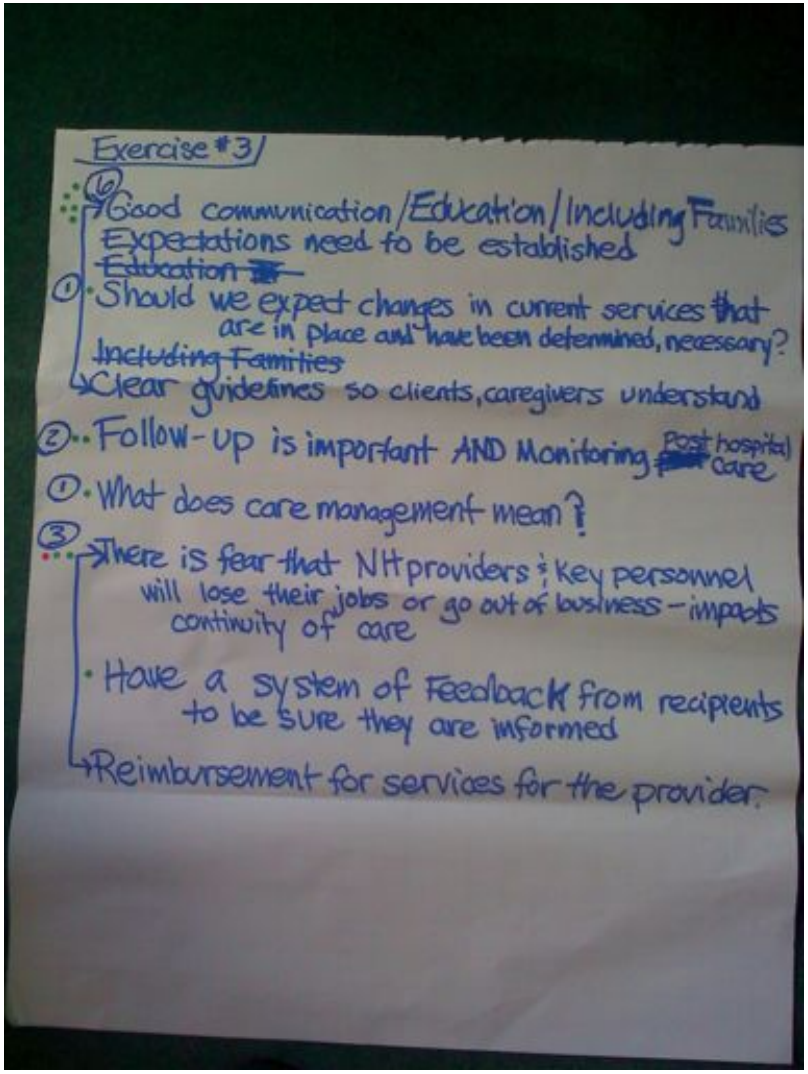



Provider "B" Summary
#1
Acces to care
No. Ctry - transportation
- geographic challenges
- Expenses
- Advocate to navigate system for patients
#2
Comprehensive Services
• wellness focus
• preventive dental
• Medical home model


Choice - providers - freedom of care providers to make health care decisions w/ patient
Medical expenses - coverage
Comprehensive services
Medical home model - ensure specialties! global considered
Advocate to assist patient to navigate system
Dental care - access + coverage preventive focus not just emergent care
wellness focus -


#3 Satisfied Providers
reimbursement rates (reasonable + adequate)
part of system - have a voice in decision-making process
Medical Home focus
fair + equitable (+ timely + accurate) systems (payment, Utilization management, disease mgmt)
streamline technology process
coordination of care
EMR supported


better coordination of all state resources | agencies to better serve clients + protect their access to services
Holistic approach to treating entire spectrum of needs (ie. BH, Emotional, economic, Physical)


Exercise #3
6
Good communication/Education/Including Families
Expectations need to be established
Education
1
Should we expect changes in current services that are in place and have been determined, necessary?
Including Families
Clear guidelines so clients, caregivers understand
2
Follow-up is important AND Monitoring post hospital care
1
What does care management mean?
3
There is fear that NH providers & key personnel will lose their jobs or go out of business - impacts continuity of care
Have a system of Feedback from recipients to be sure they are informed
Reimbursement for services for the provider

NH Medicaid
Care Management Program
Public Forum

Somersworth, NH

September 22, 2011

Disclaimer

Please note that the comments and priorities that follow reflect the opinions of participating workgroups and not necessarily those of the Department of Health and Human Services.

Photos of charts reflect workgroup work process and product. Items crossed out typically reflect brainstormed suggestions that were combined with others.

Note: In this Forum the first exercise was skipped and the definition of Quality of Life was used from the first two forums. We have documented them as Exercises 1 and 2, while the flip charts may be labeled Exercises 2 and 3.

Program User Perspective - Exercise 1

What's needed to increase # with high quality of life/health?

- Long-term supports and services as related to each individual person
- Personal care providers get the support they need – wages/benefits/training
- Equal policies for everyone – everyone gets the same choices, access to the same providers – continuity of care
- Logistics – combined care coordination – someone who understands the needs of the person, but knows what is feasible and possible in the new model – ability to reach a person – to know who to call
- person centered care – influences and informs what comes underneath it
- access to services, proper meds, equipment for recreation, easier recertification
- Meeting family needs/respite/our own choice of providers – want them to be educated and understand what is here
- Readily available – not long waits
- Ability to choose/keep current providers
- Access to the information that supports this
- In home care vs. institutionalization
- Ability to access brand name vs. generic

Provider Perspective – Exercise 1

What's needed to increase # with high quality of life/health

- Quality – adequate training, adequate access
- Funding – without funding to cover the costs of services there will be no services
- Collaborative care
- Choice – appropriate for the patient – well informed
- Structure of the system, local control
- Improved payment system
- Integration – mental health and dental care, work between providers, comprehensive array of services, prevention
- Accessibility – transport, access, affordable, medication, live people to talk to, auxiliary services
- Medical Home model – integrated access to all services
- Adequate and fair
- Easy to navigate

Program User Perspective – Exercise 2

In a care management program, what must happen in order to create **knowledgeable and informed** recipients?

- Care coordination – make sure that they know the person – and that the caseload is not so large
- Knowledge – that everyone has the same awareness of what is out there – providers/care givers/recipients
- Access to information – multiple ways to get the word out –multiple formats for people to access and understand
- Ongoing forum – website, ways to speak to other parents/care givers. Want to keep everyone on the same page (including providers and recipients)
- Well trained – when contacted – health advocacy – consistent information access – need to be experts on the health areas that they represent
- Recipients and caregivers must be part of the process
- Access to info in a database. Ability to talk to a live person to answer my questions

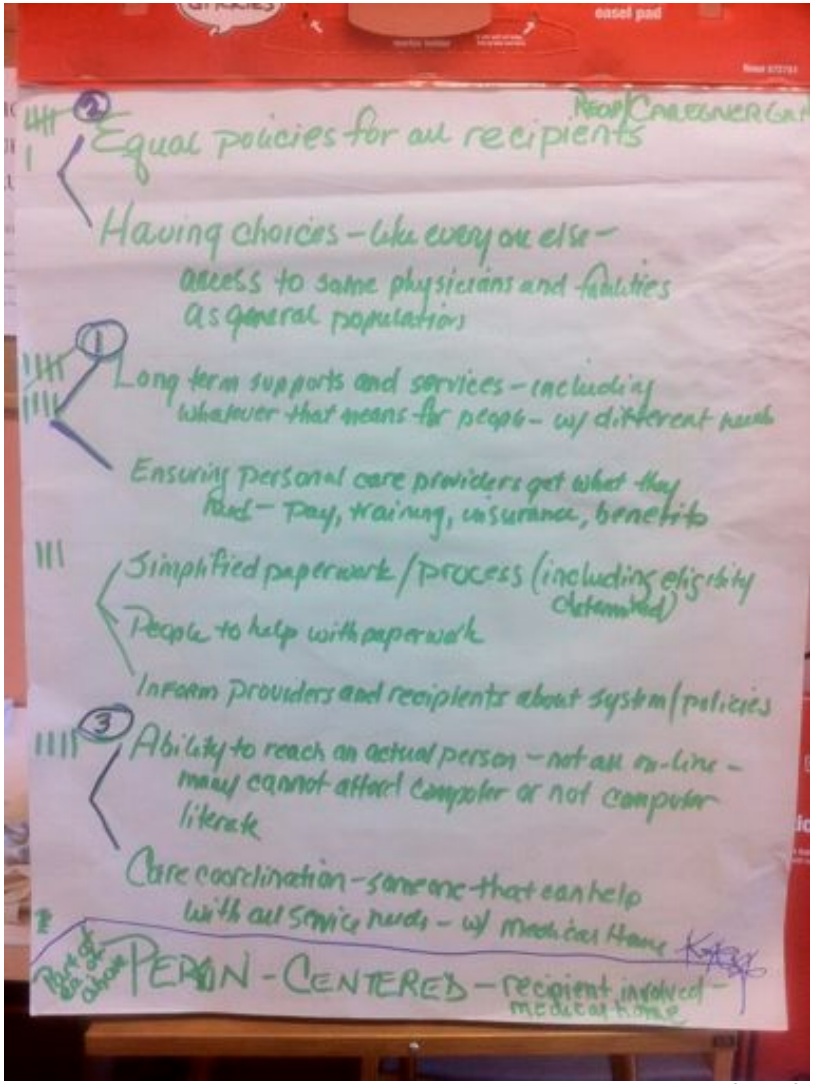
Provider Perspective – Exercise 2

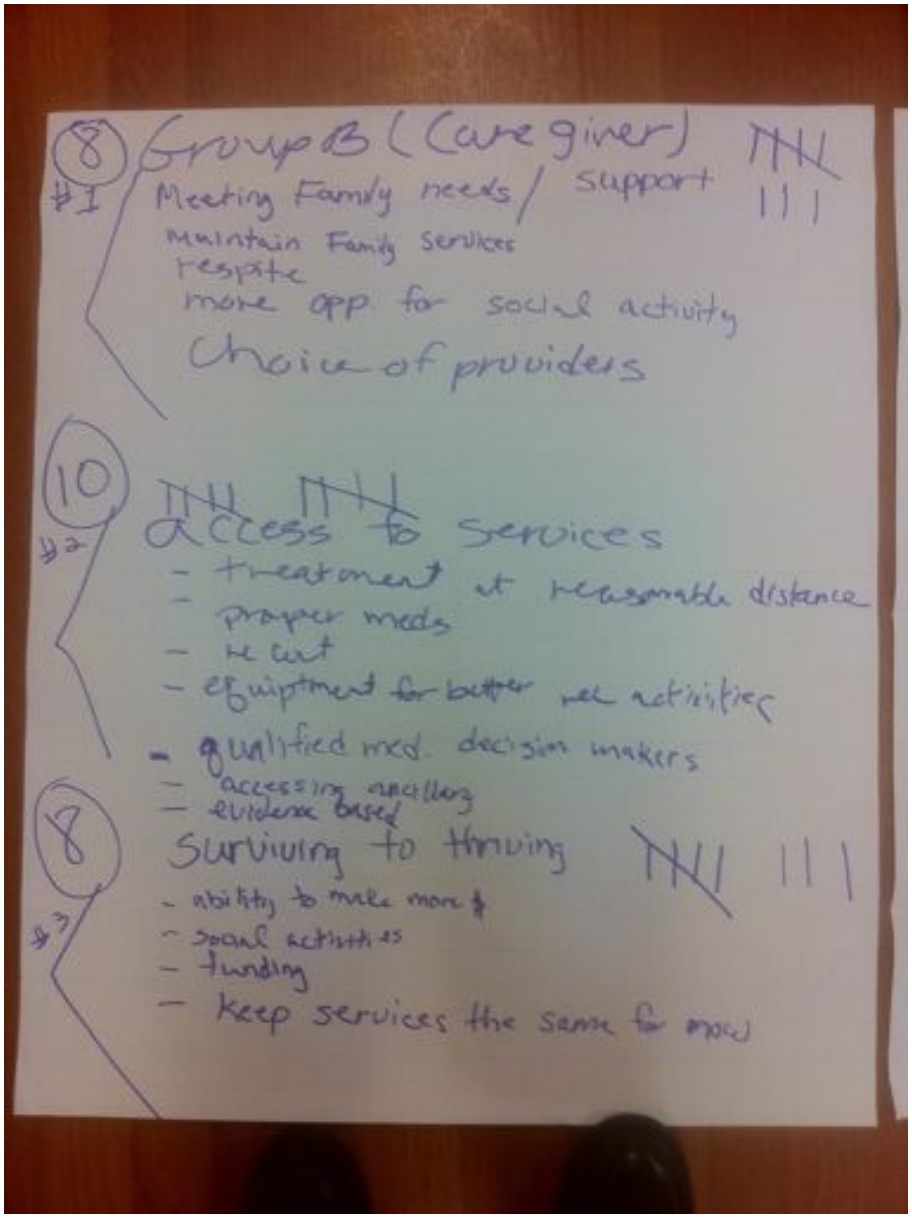
In a care management program, what must happen in order to **create satisfied providers** instead of dissatisfied (or **Resistant**) providers?

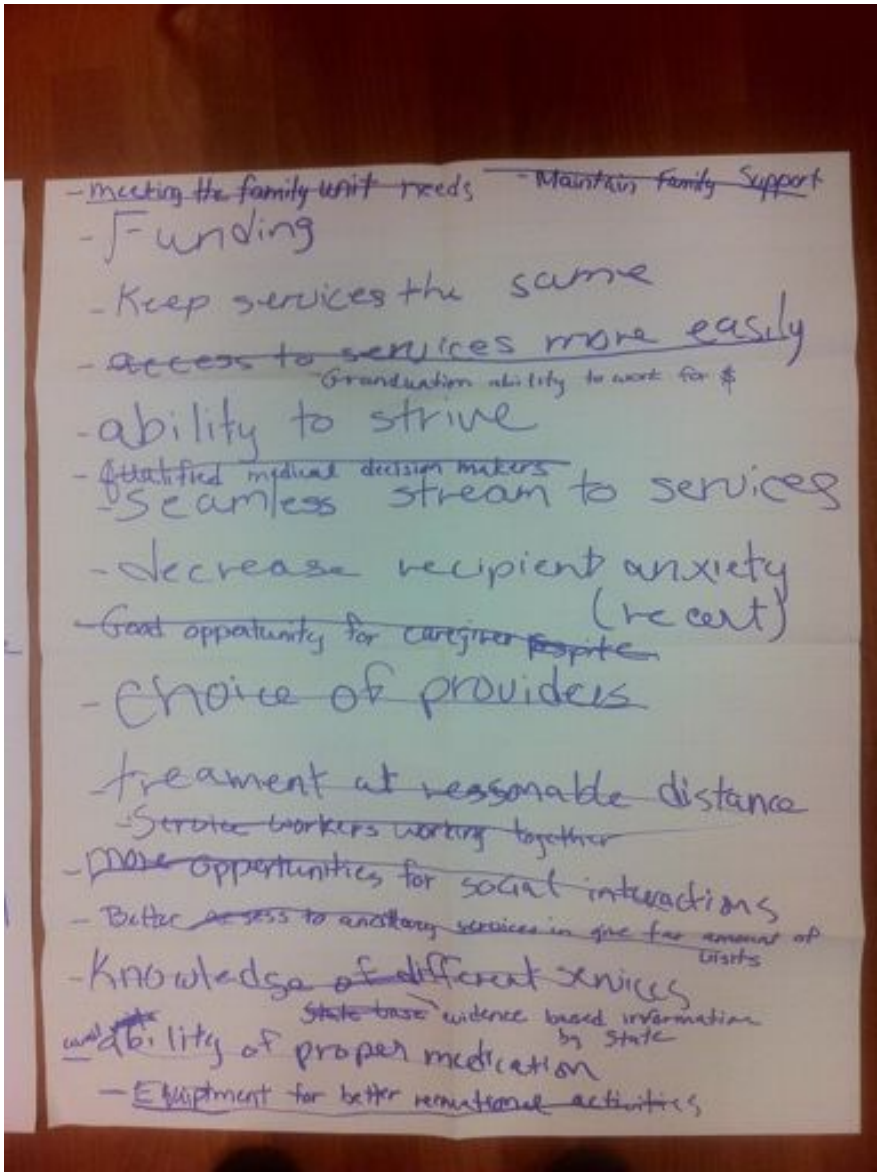
- Adequate and timely reimbursement for quality services – more prevention, more education, more case management
- Eliminating barriers to services, location, transport, prior authorization
- Patient based care, choice
- Elimination of bureaucracy
- Less litigation
- Fair pay for employees/ fair and adequate reimbursement for provider
- Transparency
- Local Control
- Whole economic system – pay to providers/stability for staff/support for clients
- Communication – whole system – listening and informing
- Medicaid has a responsibility for informing the providers/medical home about services that they are receiving.

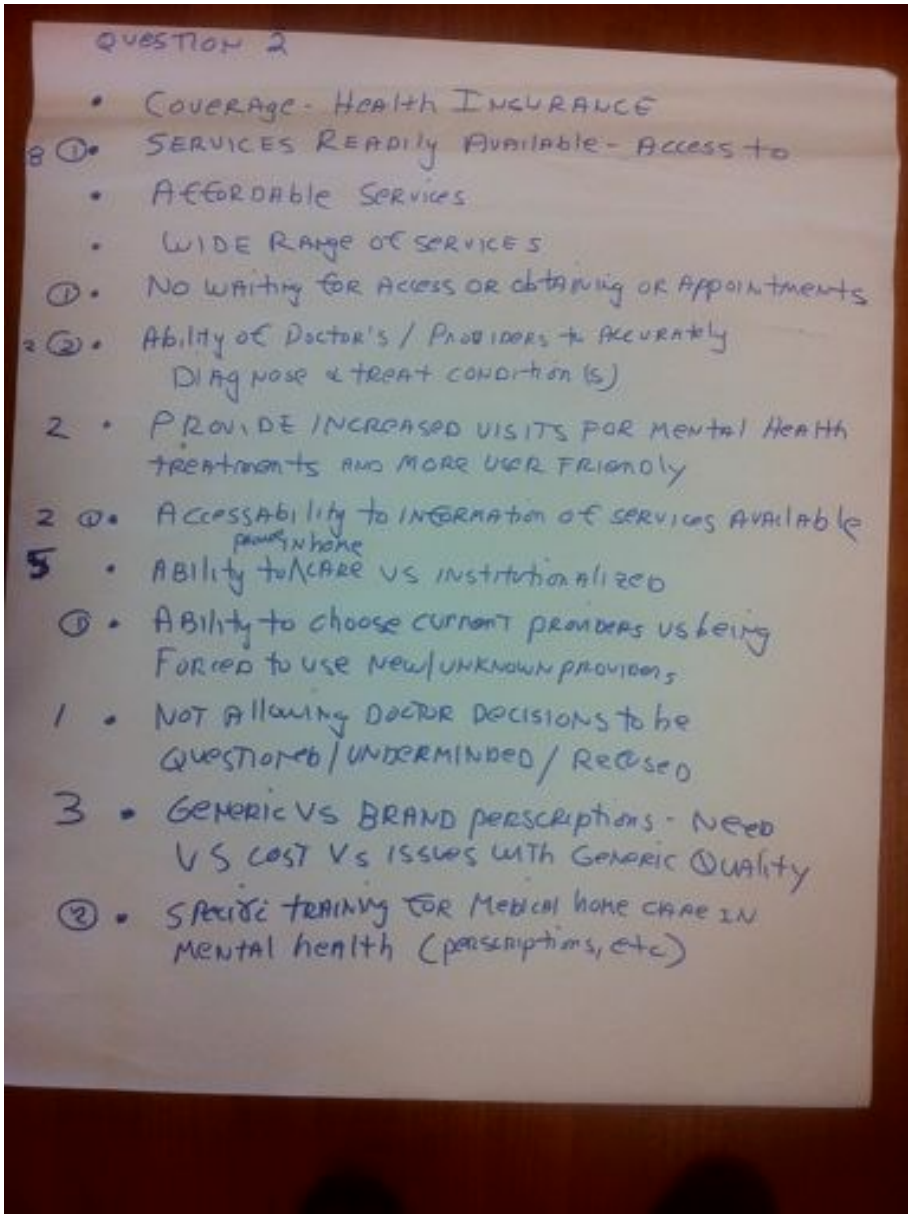
Program User Perspective - Exercise 1

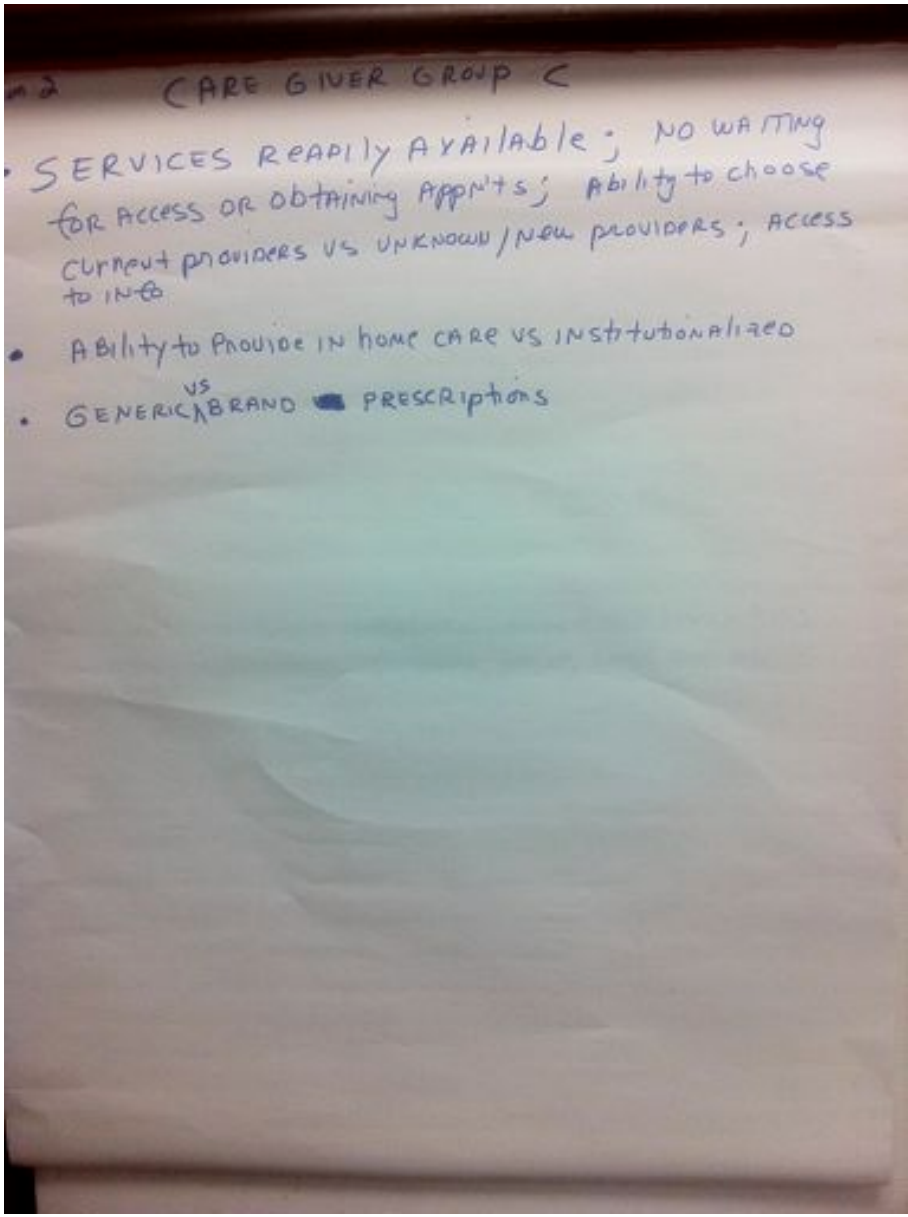
What's needed to increase # with high quality of life/health?




8
#1
Group B (Caregiver)
Meeting Family needs / support
Maintain Family Services
respite
more opp for social activity
choice of providers
10
#2
Access to services
- treatment at reasonable distance
- proper meds
- RC cert
- equipment for better rec activities
- qualified med decision makers
- accessing ancillary
- evidence based
8
#3
Surviving to thriving
- ability to make more $
- social activities
- funding
- keep services the same for now

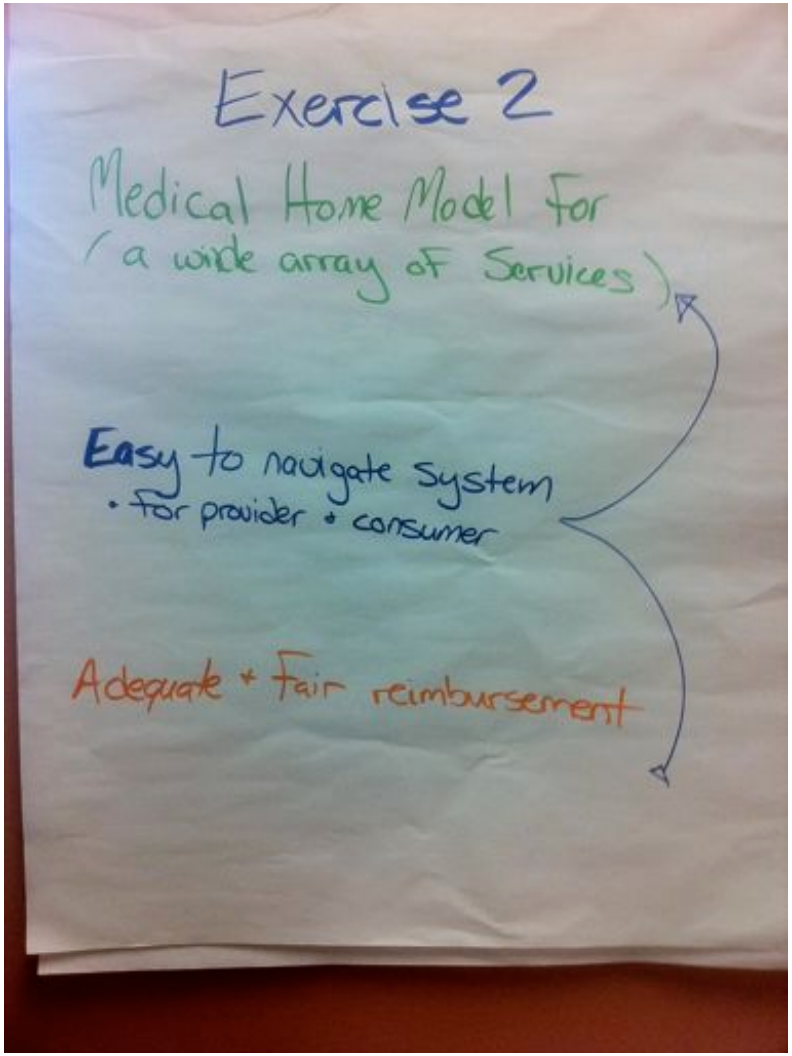

- meeting the family unit needs
- Maintain family support
- Funding
- Keep services the same
- access to services more easily
Granduation ability to work for $
- ability to strive
- qualified medical decision makers
- Seamless stream to services
- decrease recipient anxiety (recert)
- Good opportunity for caregiver respite
- choice of providers
- treament at reasonable distance
- Service workers working together
- more opportunities for social interactions
- Better access to ancillary services in one for amount of visits
- Knowledge of different services
State base evidence based information by state
- ability of proper medication
- Equipment for better recreational activities

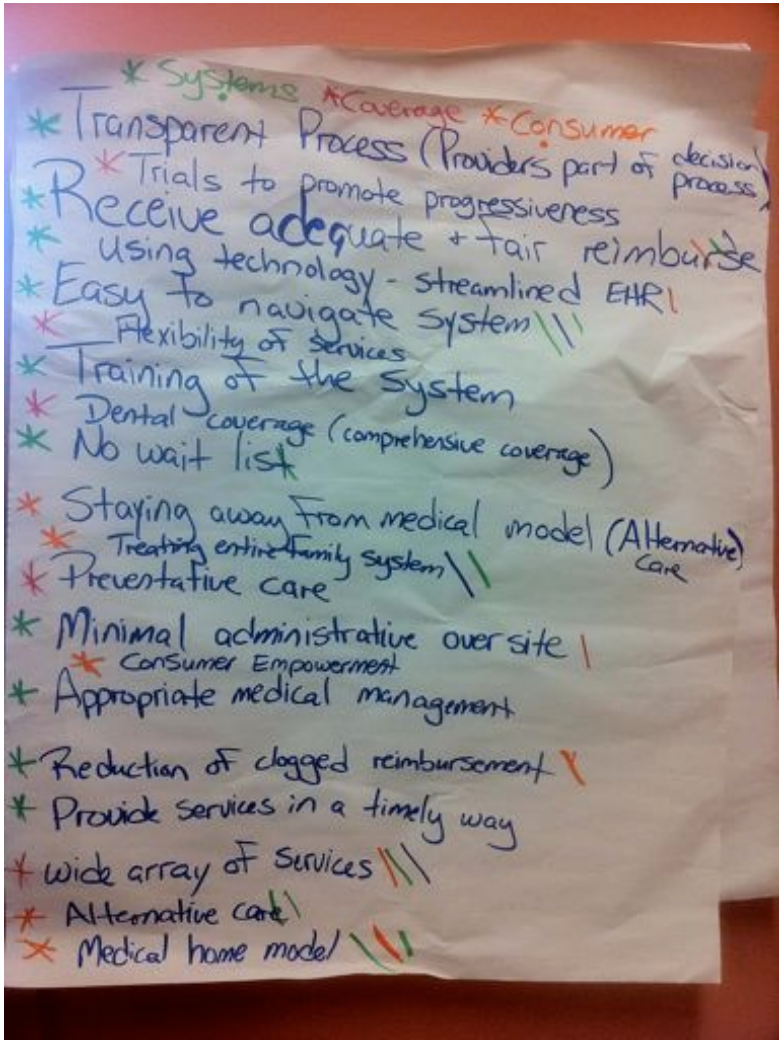

QUESTION 2
• COVERAGE - HEALTH INSURANCE
8 ① • SERVICES READILY AVAILABLE - ACCESS TO
• AFFORDABLE SERVICES
• WIDE RANGE OF SERVICES
① • NO WAITING FOR ACCESS OR OBTAINING OR APPOINTMENTS
2 ② • ABILITY OF DOCTOR'S / PROVIDERS TO ACCURATELY DIAGNOSE & TREAT CONDITION (S)
2 • PROVIDE INCREASED VISITS FOR MENTAL HEALTH TREATMENTS AND MORE USER FRIENDLY
2 ① • ACCESSABILITY TO INFORMATION OF SERVICES AVAILABLE
5 • ABILITY TO CARE (PROVIDE IN HOME) VS INSTITUTIONALIZED
① • ABILITY TO CHOOSE CURRENT PROVIDERS VS BEING FORCED TO USE NEW/UNKNOWN PROVIDERS
1 • NOT ALLOWING DOCTOR DECISIONS TO BE QUESTIONED / UNDERMINDED / REFUSED
3 • GENERIC VS BRAND PERSCRIPTIONS - NEED VS COST VS ISSUES WITH GENERIC QUALITY
② • SPECIFIC TRAINING FOR MEDICAL HOME CARE IN MENTAL HEALTH (PERSCRIPTIONS, ETC)

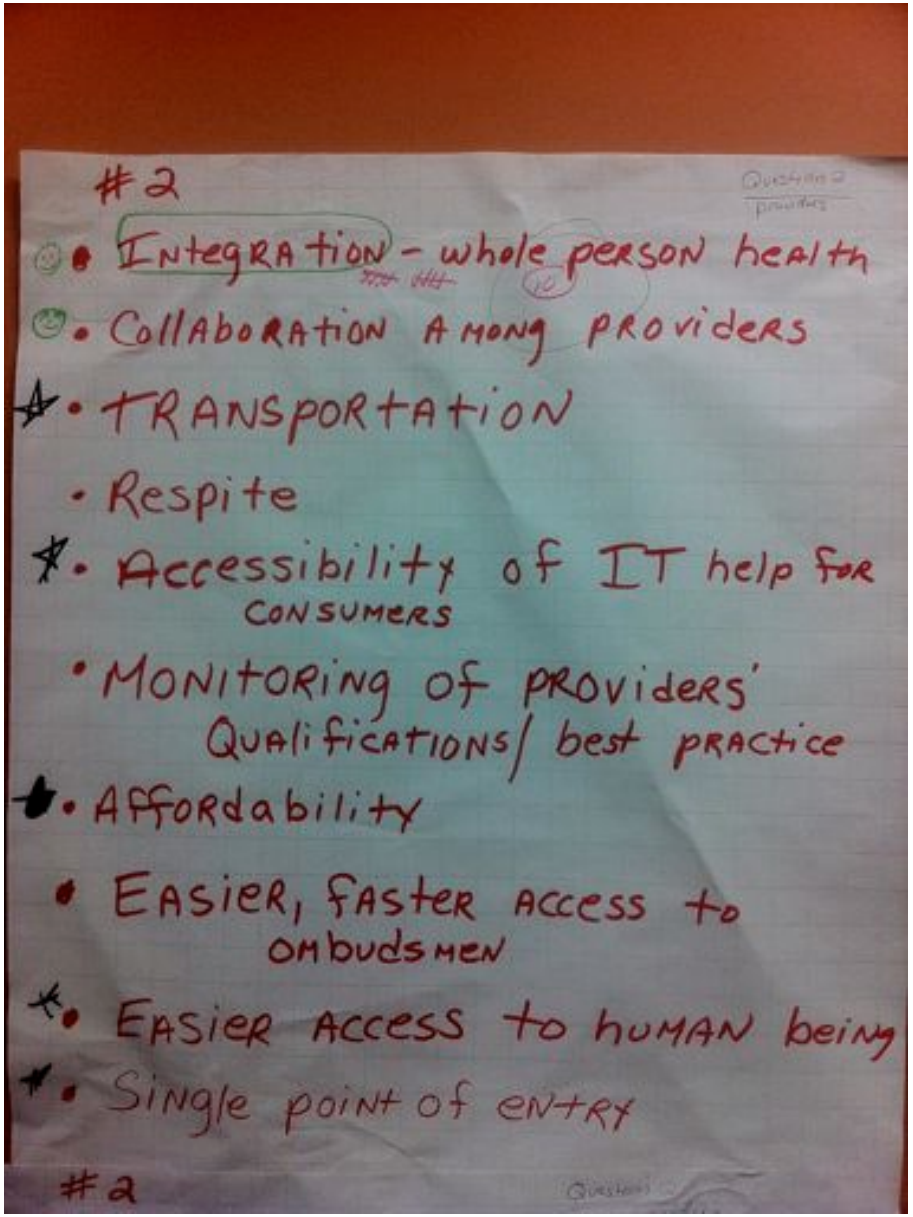

CARE GIVER GROUP C
• SERVICES READILY AVAILABLE; NO WAITING FOR ACCESS OR OBTAINING APPT'S; ABILITY TO CHOOSE CURRENT PROVIDERS VS UNKNOWN / NEW PROVIDERS; ACCESS TO INFO
• ABILITY TO PROVIDE IN HOME CARE VS INSTITUTIONALIZED
• GENERIC VS BRAND PRESCRIPTIONS

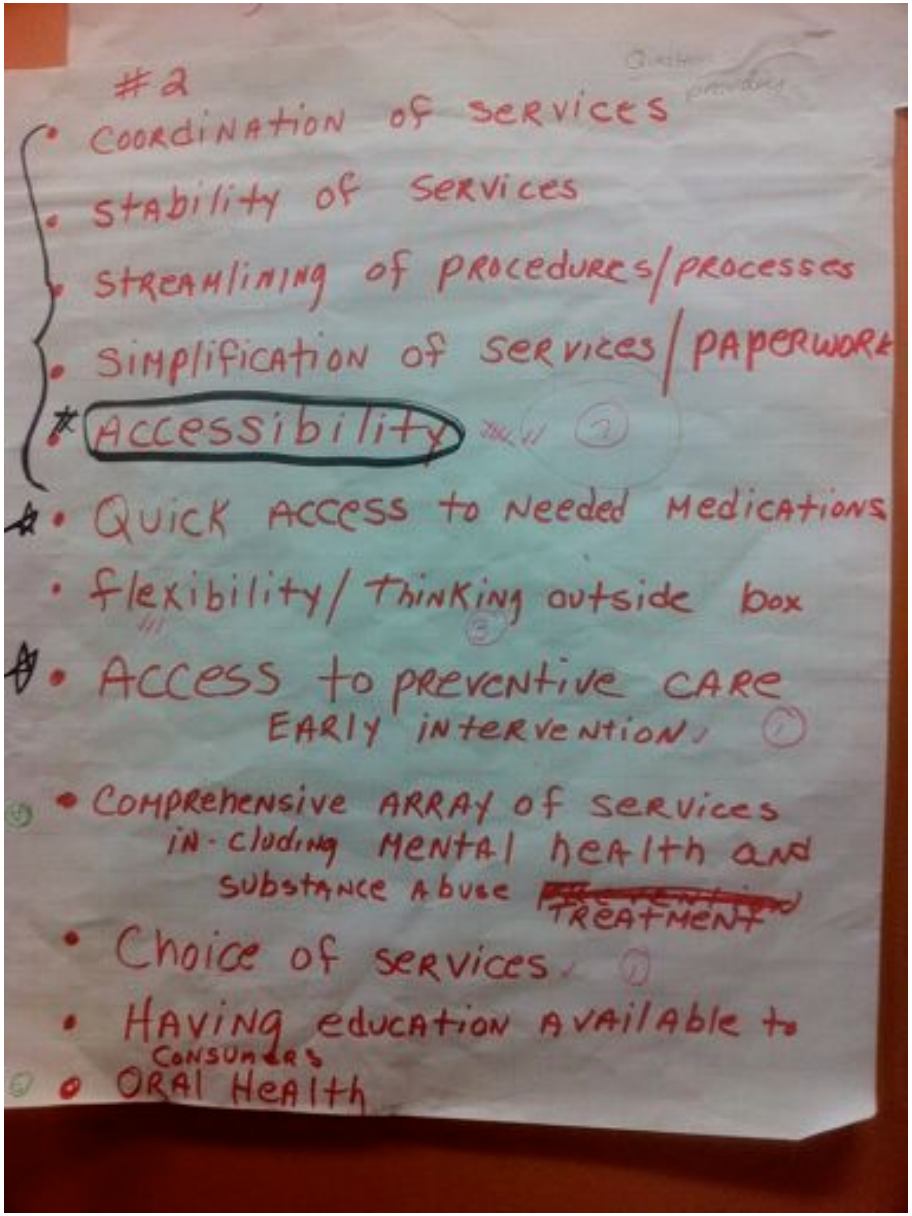
Provider Perspective – Exercise 1

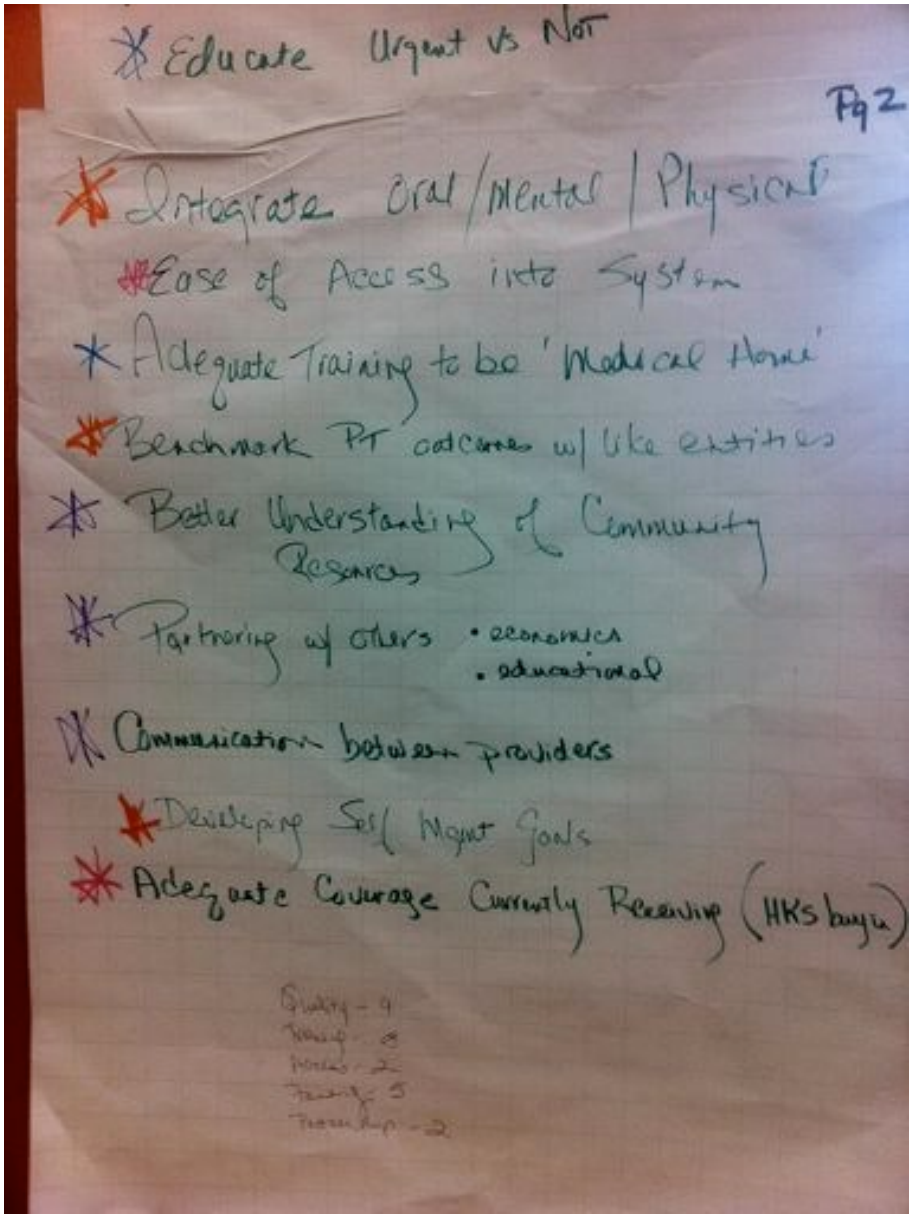
What's needed to increase # with high quality of life/health






#2
Integration - whole person health
Collaboration among providers
Transportation
Respite
Accessibility of IT help for consumers
Monitoring of providers' Qualifications/ best practice
Affordability
Easier, faster access to ombudsmen
Easier access to human being
Single point of entry
#2


#2
Coordination of services
Stability of services
Streamlining of procedures/processes
Simplification of services/paperwork
Accessibility
Quick access to needed medications
flexibility/ thinking outside box
Access to preventive care early intervention
Comprehensive array of services including mental health and substance abuse treatment
Choice of services
Having education available to consumers
Oral Health

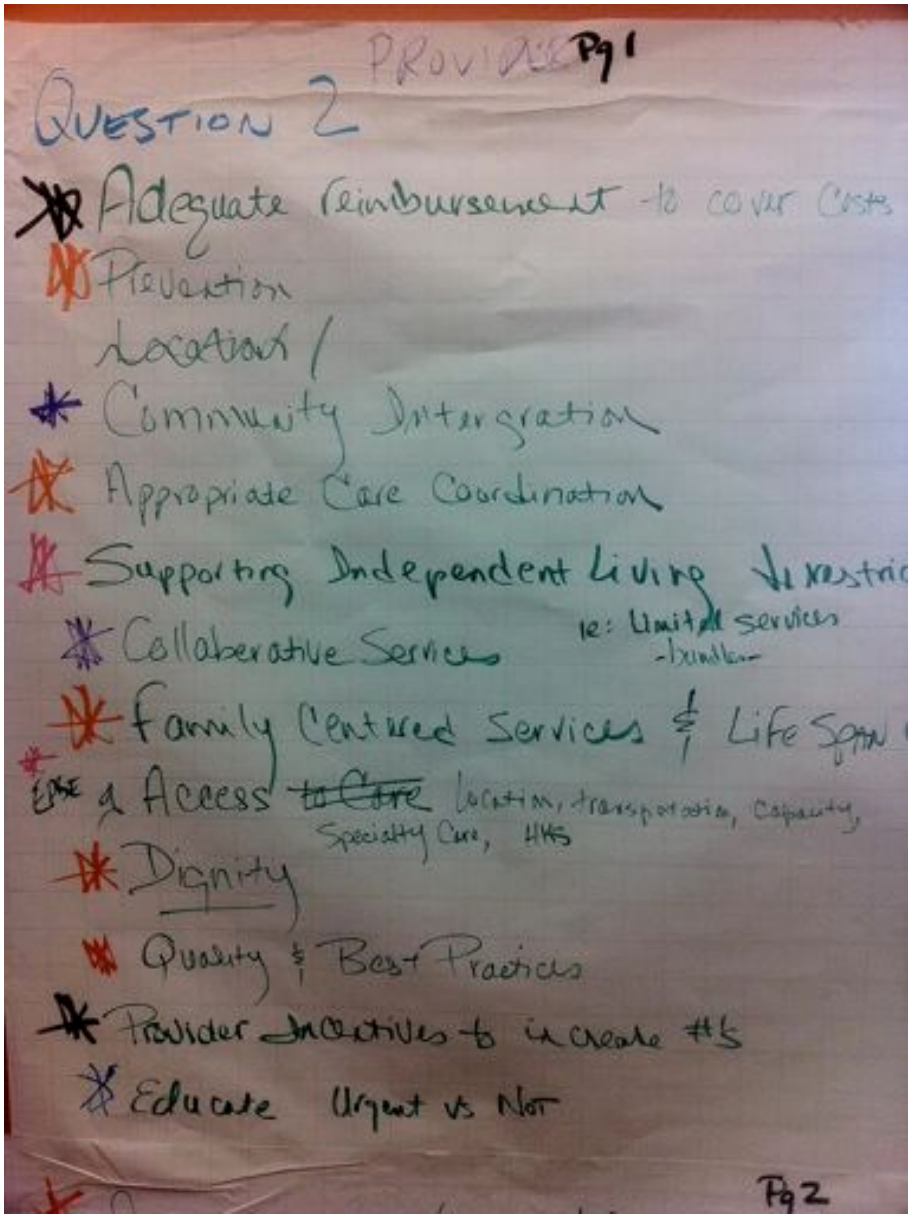


* Educate Urgent vs Not

Pg 2

* Integrate Oral / Mental / Physical
* Ease of Access into System
* Adequate Training to be 'Medical Home'
* Benchmark PT outcomes w/ like entities
* Better Understanding of Community Resources
* Partnering w/ others • economics • educational
* Communication between providers
* Developing Self Mgmt Goals
* Adequate Coverage Currently Receiving (HKS buy in)

Quality - 9
[illegible] - 8
[illegible] - 2
[illegible] - 5
[illegible] - 2

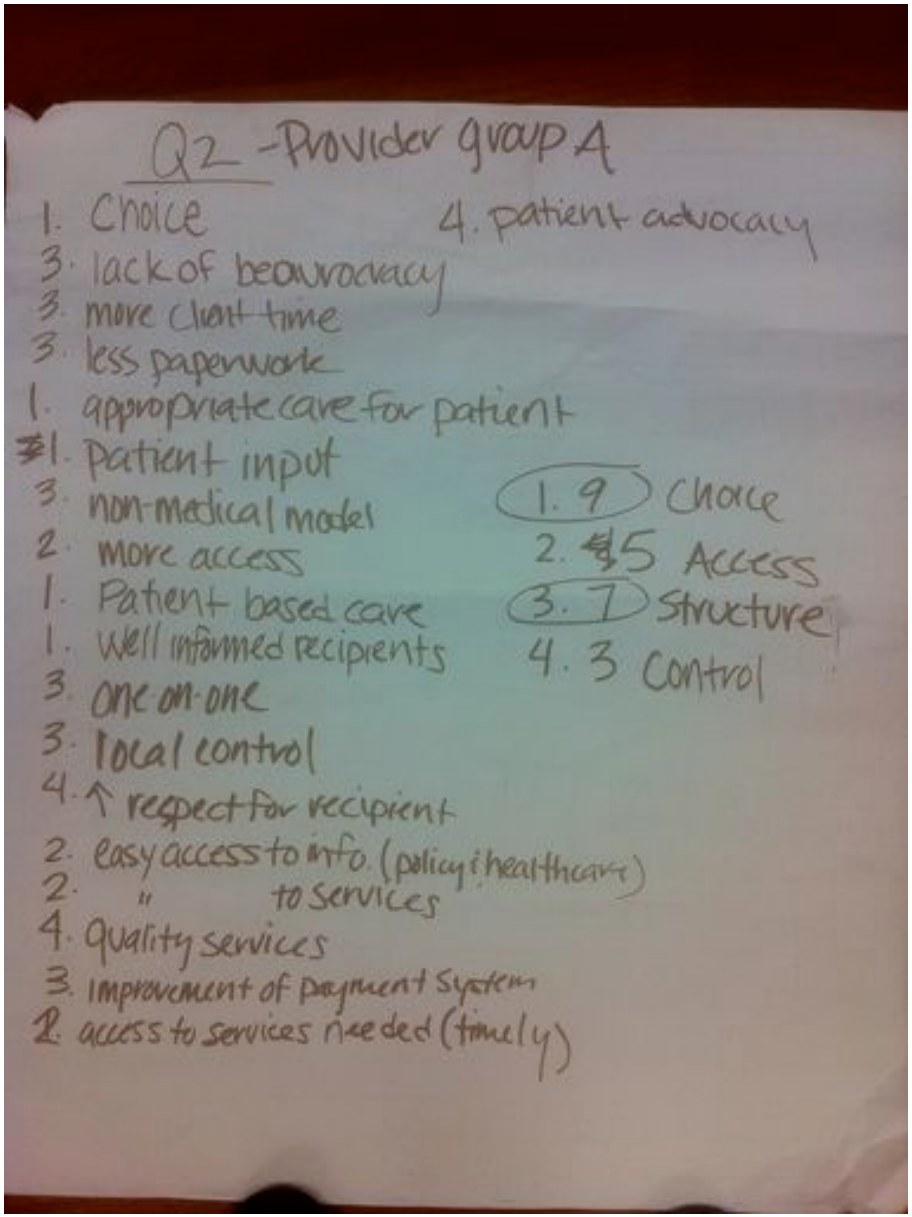


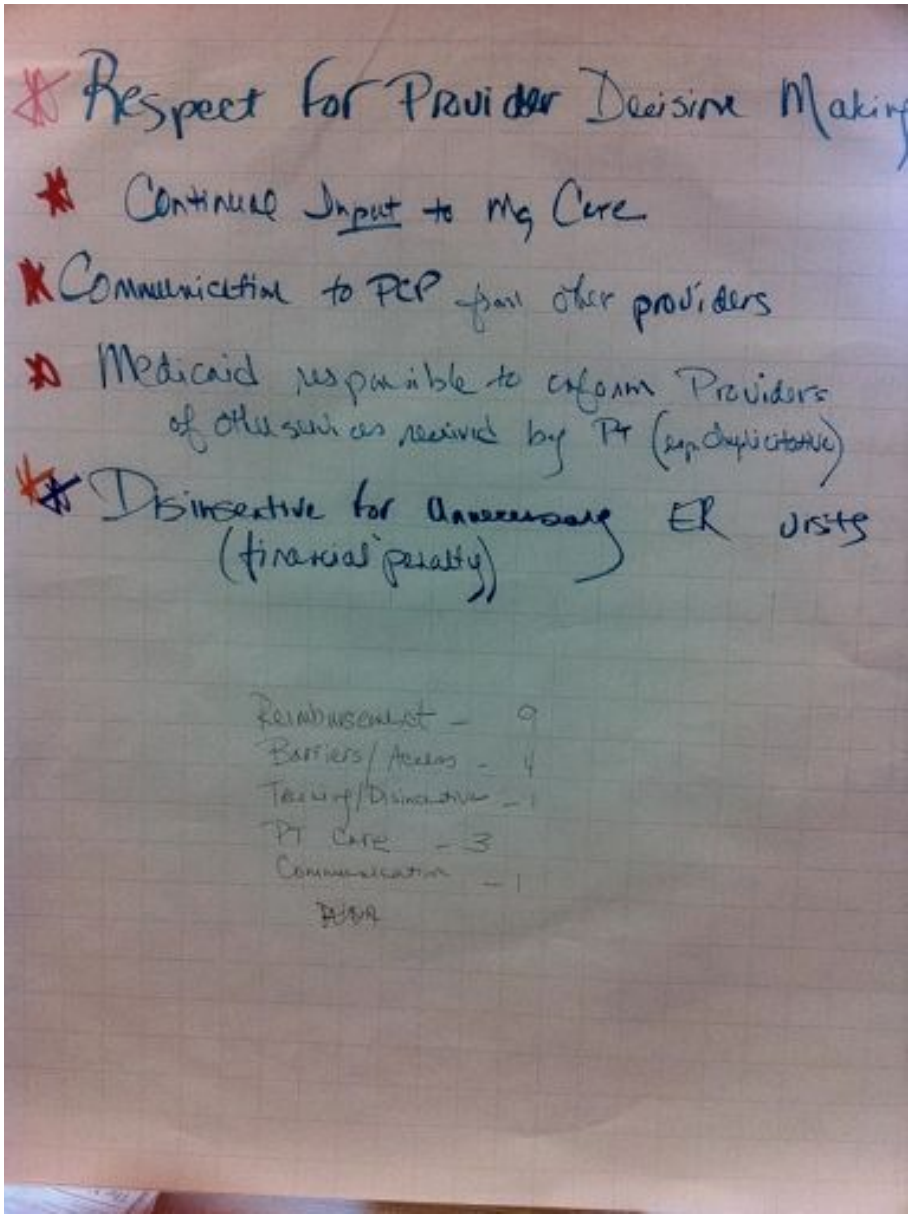
PROVIDER Pg 1

QUESTION 2

* Adequate Reimbursement - to cover Costs
* Prevention
* Location /
* Community Integration
* Appropriate Care Coordination
* Supporting Independent Living w/ restric
* Collaberative Services ie: Limited services - location
* Family Centered Services & Life Span
* Ease & Access ~~to Care~~ location, transportation, Capacity, Specialty Care, HKS
* Dignity
* Quality & Best Practices
* Provider ~~Incentives~~ to increase #'s
* Educate Urgent vs Not

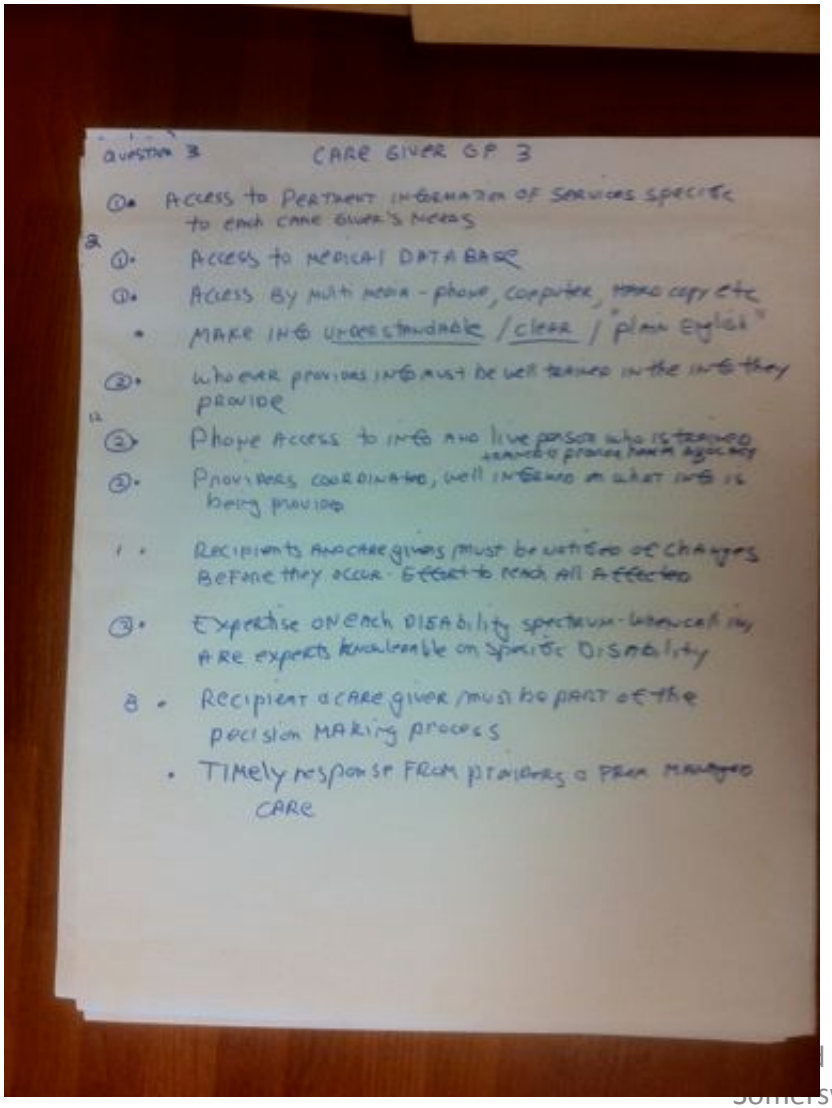
Pg 2

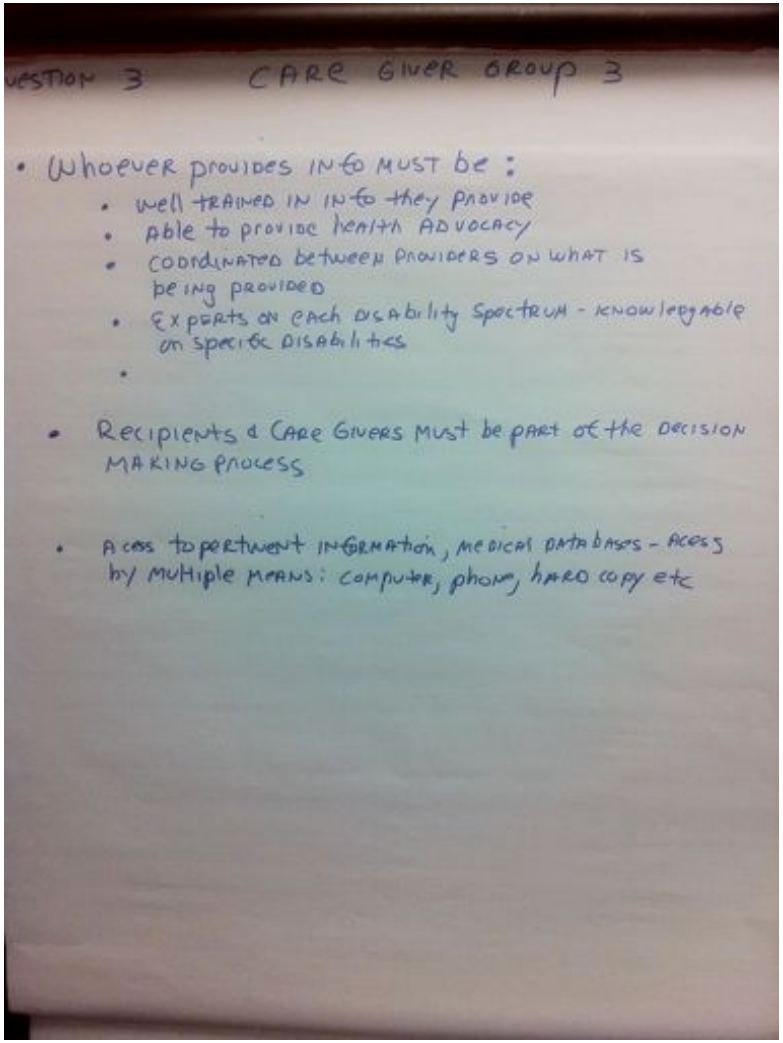

Q2 - Provider group A
1. Choice
4. patient advocacy
3. lack of beaurocracy
3. more client time
3. less paperwork
1. appropriate care for patient
#1. patient input
3. non-medical model
2. more access
1. Patient based care
1. well informed recipients
3. one on one
3. local control
4. ↑ respect for recipient
2. easy access to info. (policy/healthcare)
2. " to services
4. quality services
3. improvement of payment system
2. access to services needed (timely)
1.9 Choice
2.5 Access
3.7 Structure
4.3 Control

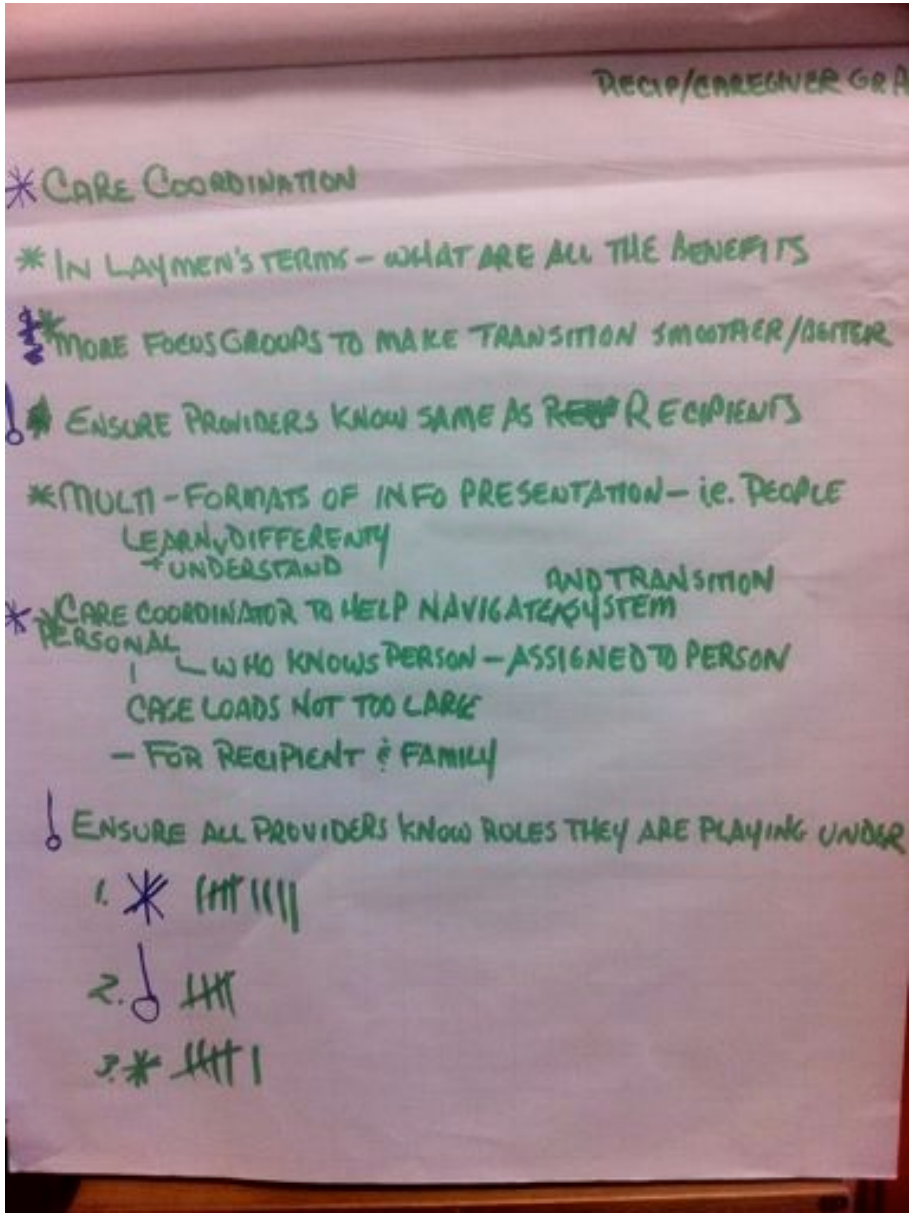

Respect for Provider Decision Making
Continual Input to My Care
Communication to PCP from other providers
Medicaid responsible to inform Providers of other services received by Pt (esp. duplications)
Disincentive for Unnecessary ER visits
(financial penalty)
Reimbursement - 9
Barriers/Access - 4
Testing/Disincentive - 1
Pt Care - 3
Communication - 1

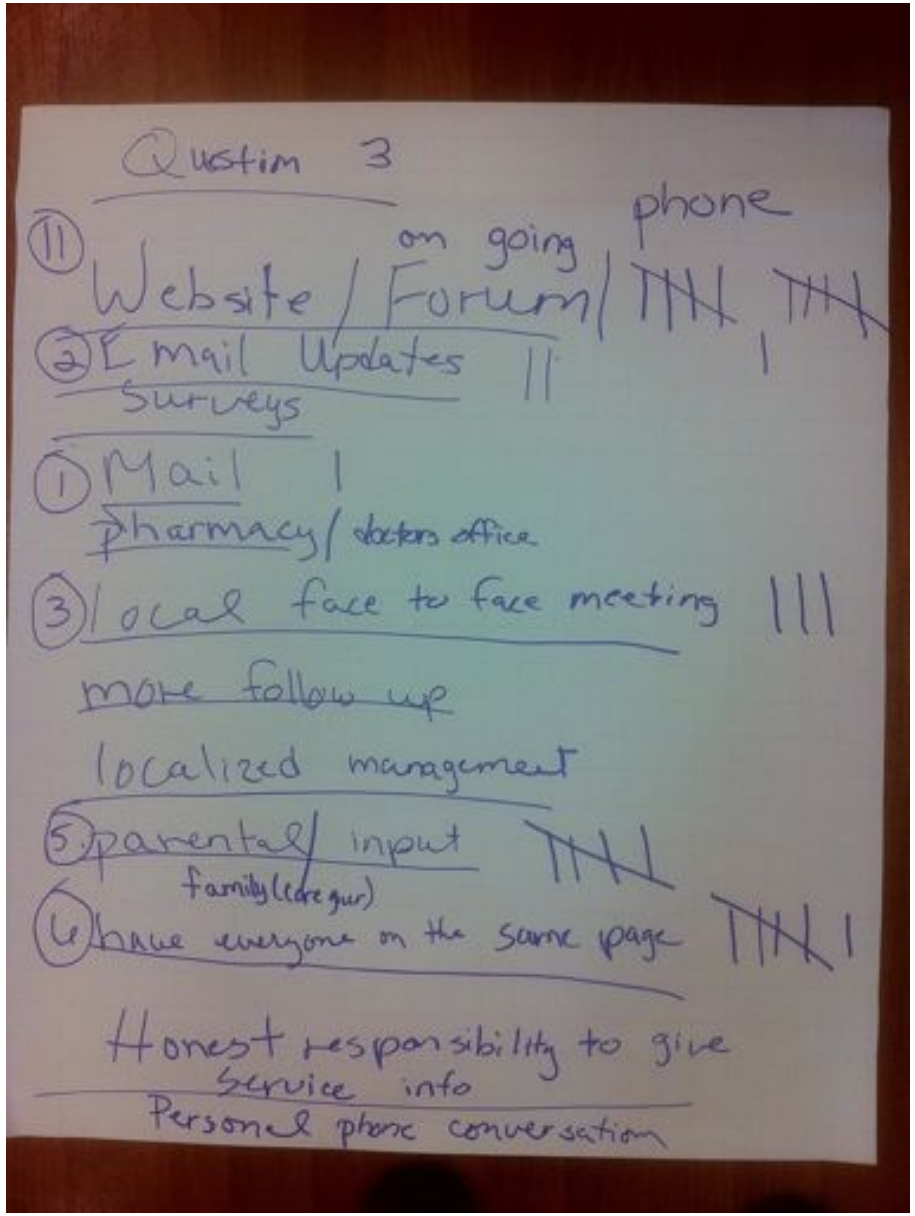
Program User Perspective – Exercise 2

In a care management program, what must happen in order to create **knowledgeable and informed** recipients?



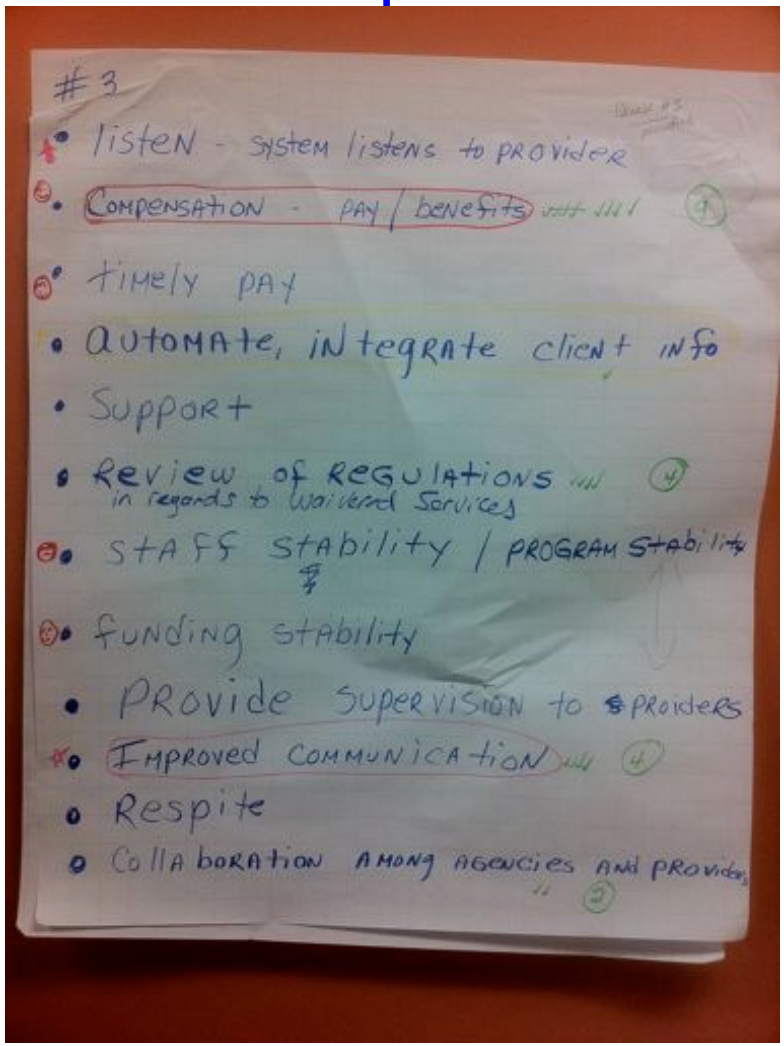


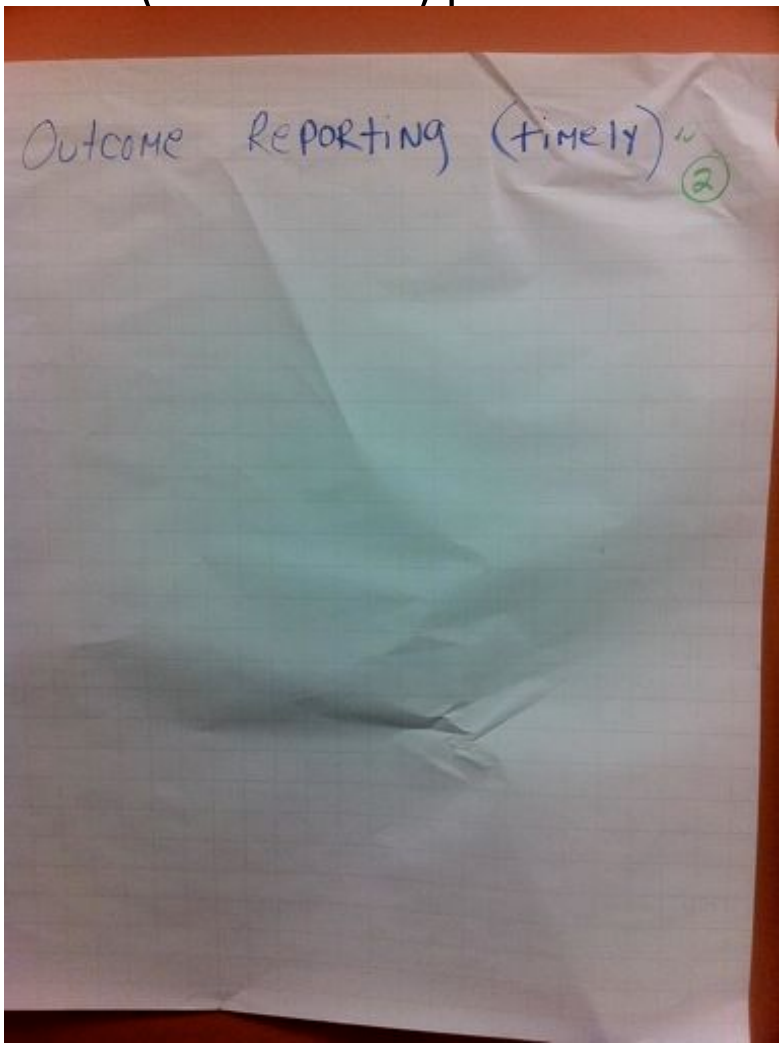

RECIP/CAREGIVER GR
* CARE COORDINATION
* IN LAYMEN'S TERMS – WHAT ARE ALL THE BENEFITS
* MORE FOCUS GROUPS TO MAKE TRANSITION SMOOTHER/BETTER
* ENSURE PROVIDERS KNOW SAME AS RECIPIENTS
* MULTI-FORMATS OF INFO PRESENTATION – ie. PEOPLE LEARN DIFFERENTLY + UNDERSTAND
* CARE COORDINATOR TO HELP NAVIGATE SYSTEM AND TRANSITION
PERSONAL
WHO KNOWS PERSON – ASSIGNED TO PERSON
CASE LOADS NOT TOO LARGE
– FOR RECIPIENT & FAMILY
ENSURE ALL PROVIDERS KNOW ROLES THEY ARE PLAYING UNDER
1. * IIII
2. IIII
3. * IIII

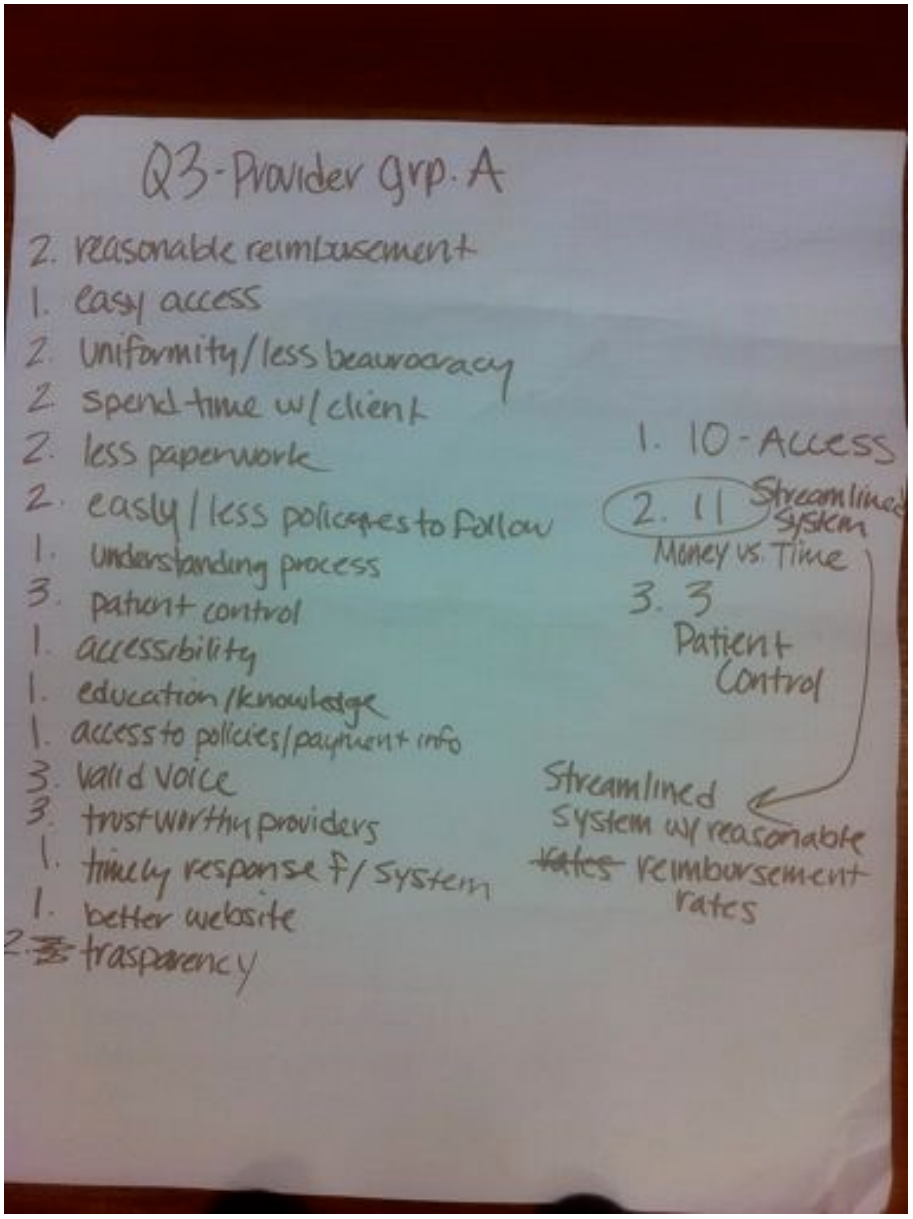

Questim 3
(11) on going phone
Website / Forum / IIII IIII
(2) Email Updates II
Surveys
(1) Mail I
Pharmacy / doctors office
(3) local face to face meeting III
more follow up
localized management
(5) parental / input IIII
family (caregiver)
(4) have everyone on the same page IIII I
Honest responsibility to give service info
Personal phone conversation

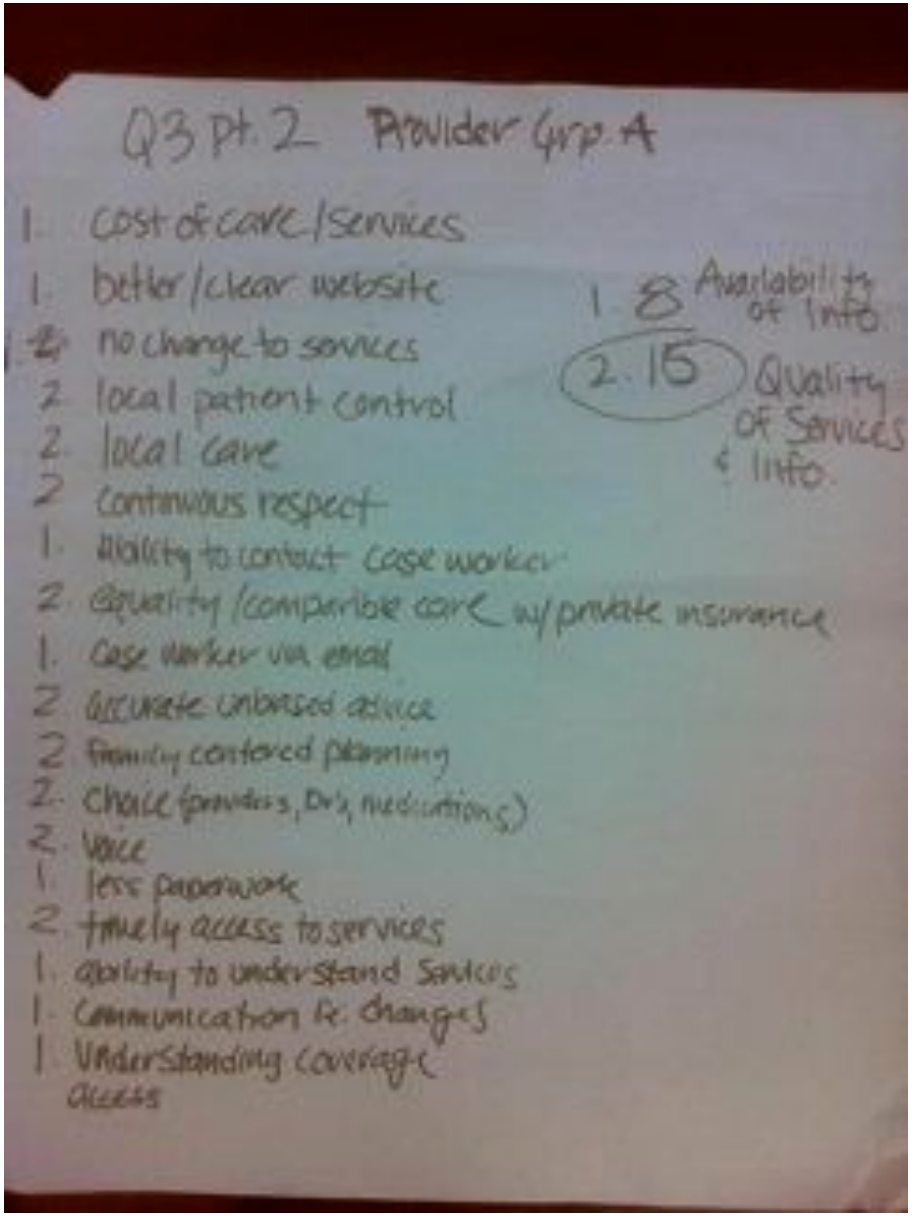
Provider Perspective – Exercise 2

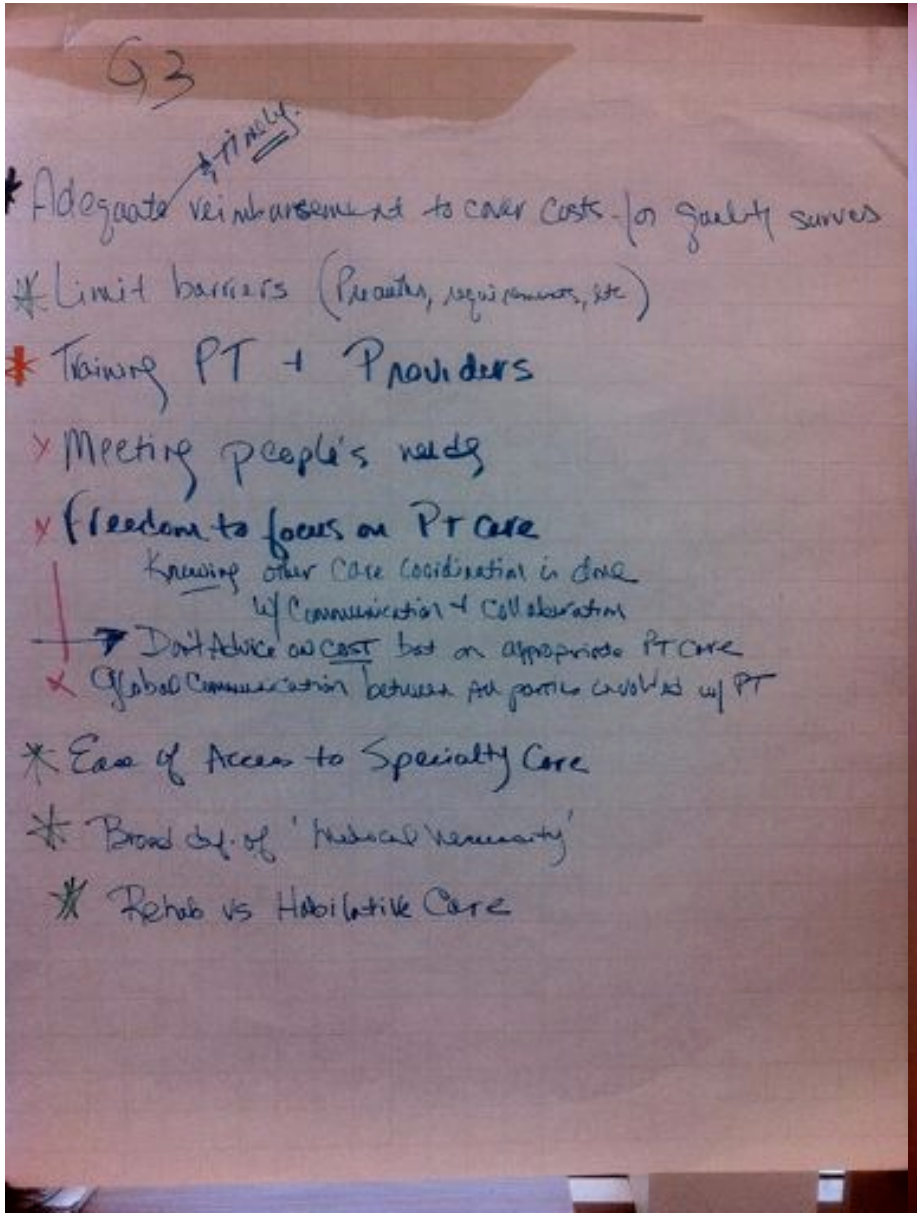
In a care management program, what must happen in order to **create satisfied providers** instead of dissatisfied (or **Resistant**) providers?

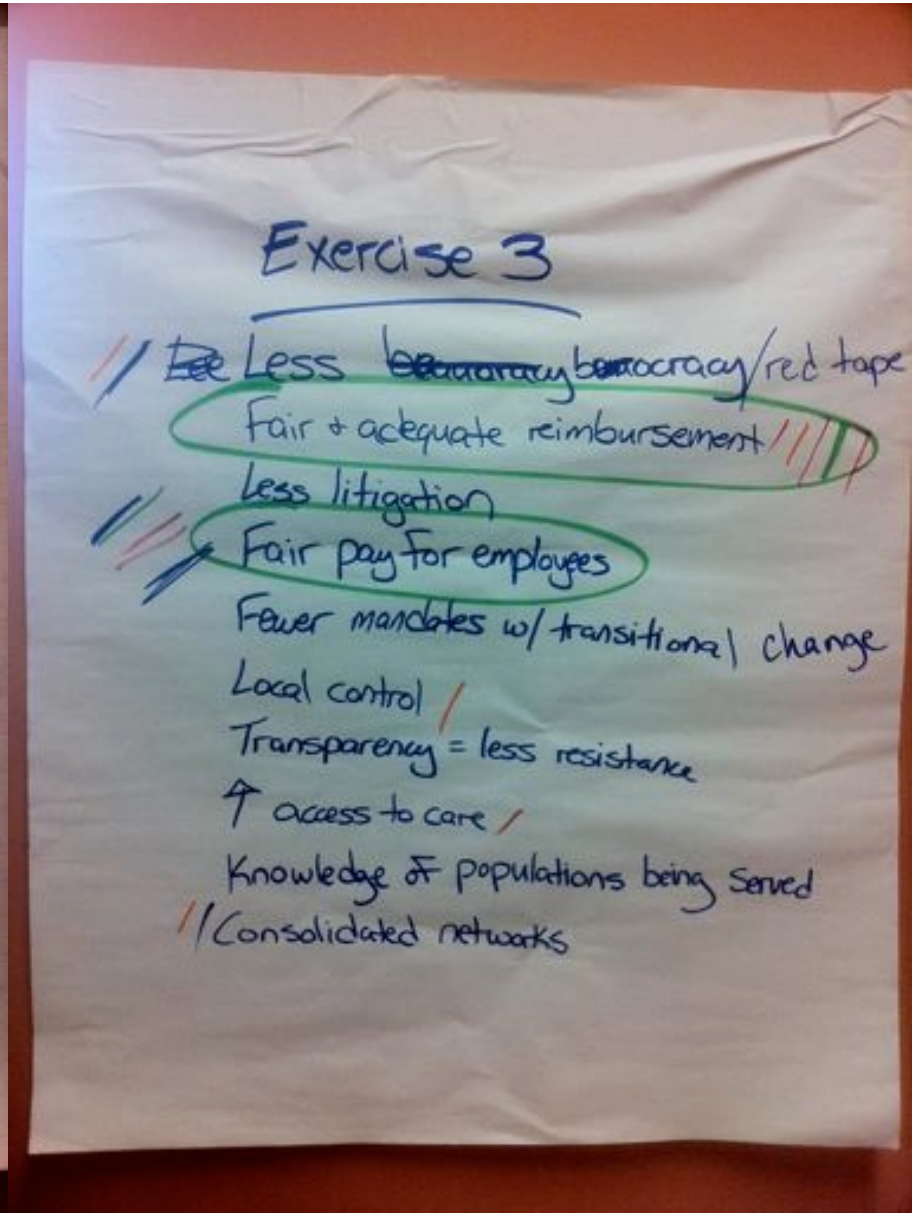





Q3 - Provider grp. A
2. reasonable reimbursement
1. easy access
2. uniformity / less beaurocracy
2. spend time w/ client
2. less paperwork
2. easily / less policies to follow
1. understanding process
3. patient control
1. accessibility
1. education / knowledge
1. access to policies / payment info
3. valid voice
3. trustworthy providers
1. timely response f/ system
1. better website
2. trasparency
1. 10 - Access
2. 11 Streamlined System
Money vs. Time
3. 3
Patient Control
Streamlined System w/ reasonable reimbursement rates


Q3 pt. 2 Provider Grp. A
1. cost of care / services
1. better / clear website
1. 8 Availability of Info.
2. no change to services
2. 15 Quality of Services & Info.
2 local patient control
2. local care
2 continuous respect
1. ability to contact case worker
2. equality / comparable care w/ private insurance
1. case worker via email
2 accurate unbiased advice
2 family centered planning
2. choice (providers, Dr's, medications)
2. voice
1. less paperwork
2 timely access to services
1. ability to understand services
1. communication re. changes
1 understanding coverage
access


G3
Adequate reimbursement to cover costs for quality services
Limit barriers (Prior auth, requirements, etc)
Training PT + Providers
Meeting people's needs
Freedom to focus on PT care
Knowing other care coordination is done
w/ Communication + Collaboration
Don't Advice on cost but on appropriate PT Care
Global Communication between all parties involved w/ PT
Ease of Access to Specialty Care
Broad def. of 'Medical Necessity'
Rehab vs Habilitative Care


Exercise 3
Less bureaucracy/red tape
Fair + adequate reimbursement
Less litigation
Fair pay for employees
Fewer mandates w/ transitional change
Local control
Transparency = less resistance
↑ access to care
Knowledge of populations being served
Consolidated networks

NH Medicaid
Care Management Program
Public Forum

Manchester, NH

September 23, 2011

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Program Users Perspective - Exercise 1

What's needed to increase # with high quality of life/health?

- Progression and stability as acceptable outcomes
- Eligibility based on recipient not caregiver income
- Doctors free from outside pressure
- Patient/Family Control
- Appeal rights on denial
- Community Cultural Change of Attitude
- Access to range of info making it geographically convenient and accessible
- Consistent standards implemented across all agencies and users
- Integrated whole family approach
- Wellness versus treatment
- Quality customer service follow up with enough personnel
- Quality and individual control meaning individual and provider or doctor make decisions. Not a one size fits all approach. In particular do not want services to be stopped simply because program user is not showing improvement.
- Communication to user in an easy to understand way. With someone they can talk to who knows them.
- Need to decide as a society on a common value…an agreed baseline in health and service access should be established as a right to every citizen.
- Person centered system that gives consumers choices and variety of health care providers (an increased pool of providers that are adequately reimbursed)
- A proactive case managed system that integrates services across the health and services program including prevention, education, and services all in one stop environment
- Different models of delivery (rural versus city) based on needs of a diverse population (including transport, mental health, substance abuse)

Provider Perspective – Exercise 1

What's needed to increase # with high quality of life/health

- Accessibility
- Preventative Care
- Accountability
- Fair and stable reimbursement including payment reform for innovation
- Comprehensive array of services to make appropriate referrals
- Better accountability at DHHS including an organization chart so providers know who to go to and can eliminate administrative barriers
- Guaranteed access
- Sufficient state and federal funding
- Face to face appeals based on medical necessity with focus on care improvement rather than denials.
- More education and follow up
- Funding and regulatory flexibility
- Integrated system of care using evidence based guidelines
- Access to quality providers – including transportation, home based care
- Care coordination utilizing a HUMAN response system to manage interagency coordination and referrals.

Program User Perspective – Exercise 2

In a care management program, what must happen in order to create **knowledgeable and informed** recipients?

- Access to benefits specialist, case manager who is an advocate.
- Easy and timely to get in, no fear of immigration and other reprisal
- Communication: clear, concise, in client language, and web based
- Case managers who are knowledgeable, proactive, and flexible to client needs
- Patient control of decisions and services
- Local Control and family involvement to encourage communication and involvement
- Better informed providers and a constant give and take so that they can communicate what they need. Bottom up rather than top down approach.
- Dissemination of info: understandable, easy to interpret, multiple media and outreach programs, local community access, informed providers (not just Medicaid users), peer support groups, survey to determine consumer limitations (i.e. no access to internet or English)
- User Accountability – they need to be open and willing to take in information (advocates needed for those with issues that limit accountability)
- Informative newsletters (electronic or paper) that are mailed out so they can have info readily accessible
- Accessible informational seminars and forums with transportation availability.
- More support groups with access to legislators
- Single point of access to care through medical home or PCP
- Succinct, understandable 4th grade level information
- Need to help users navigate the system (ideally through Medical Home)

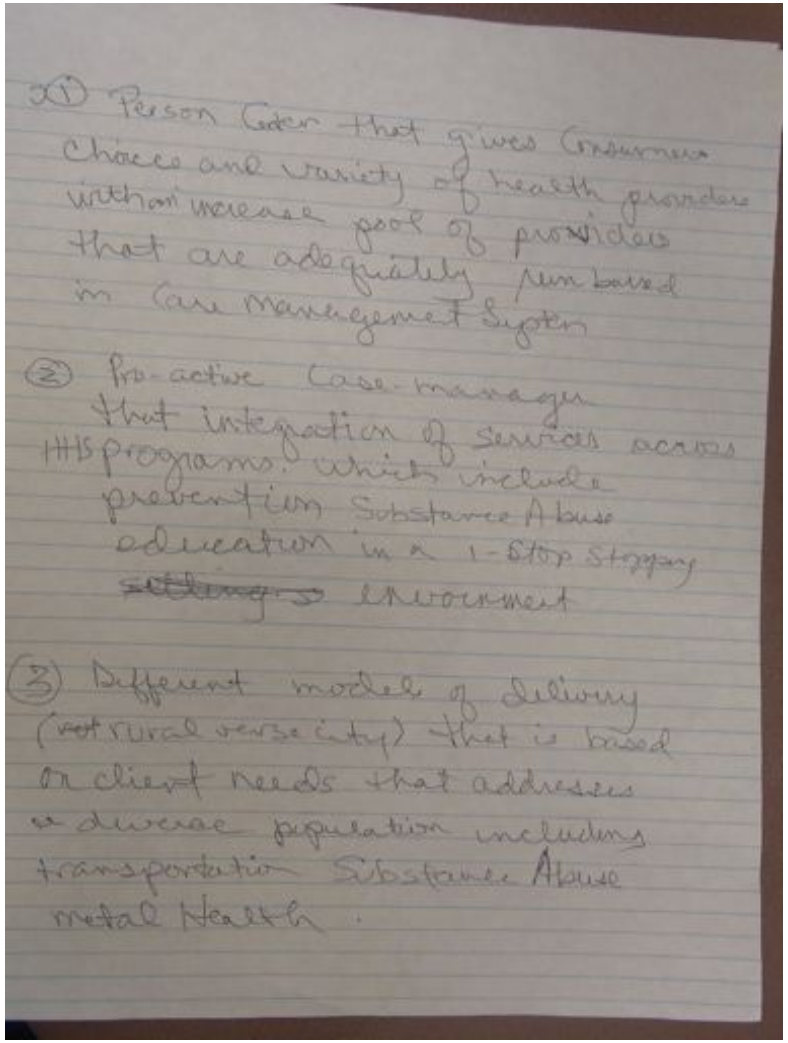
Provider Perspective – Exercise 2

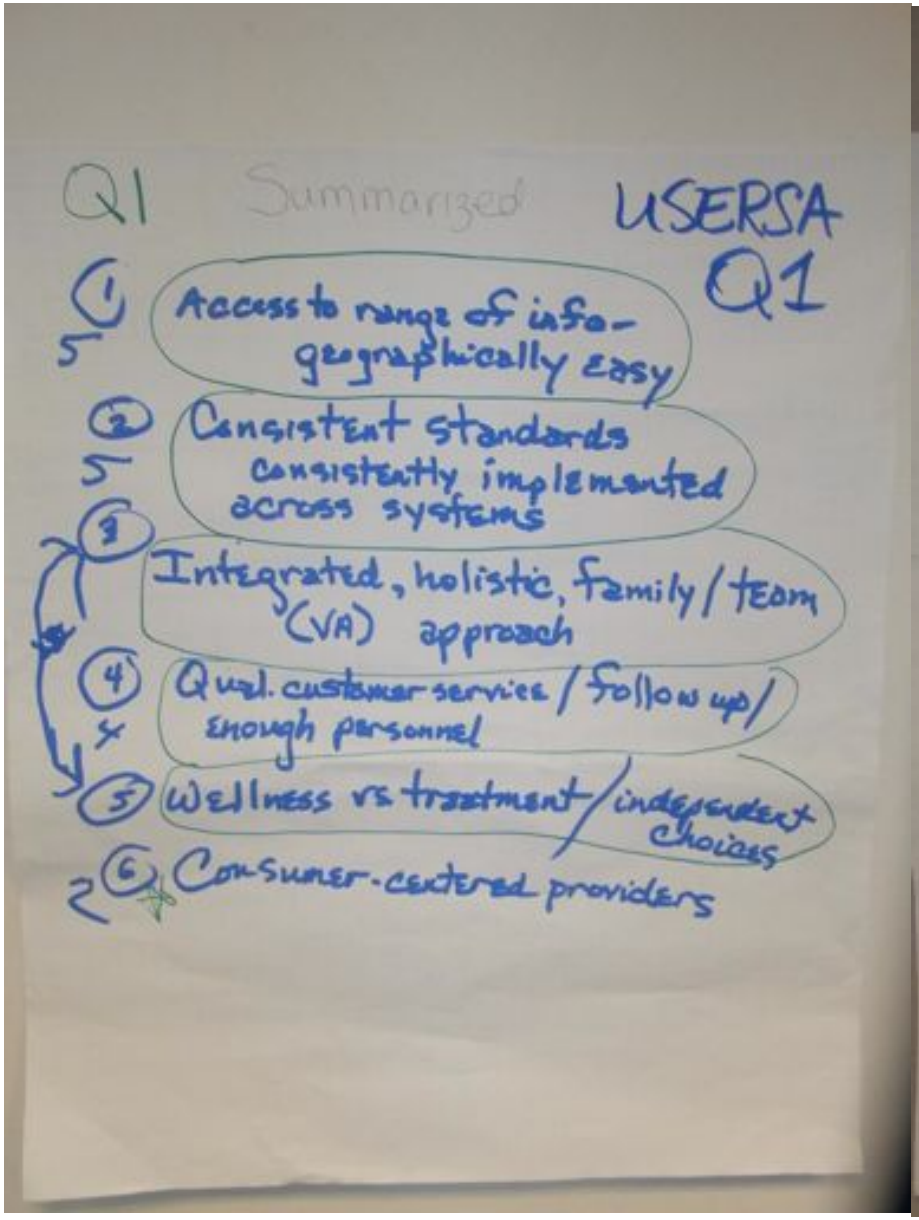
In a care management program, what must happen in order to **create satisfied providers** instead of dissatisfied (or **Resistant**) providers?

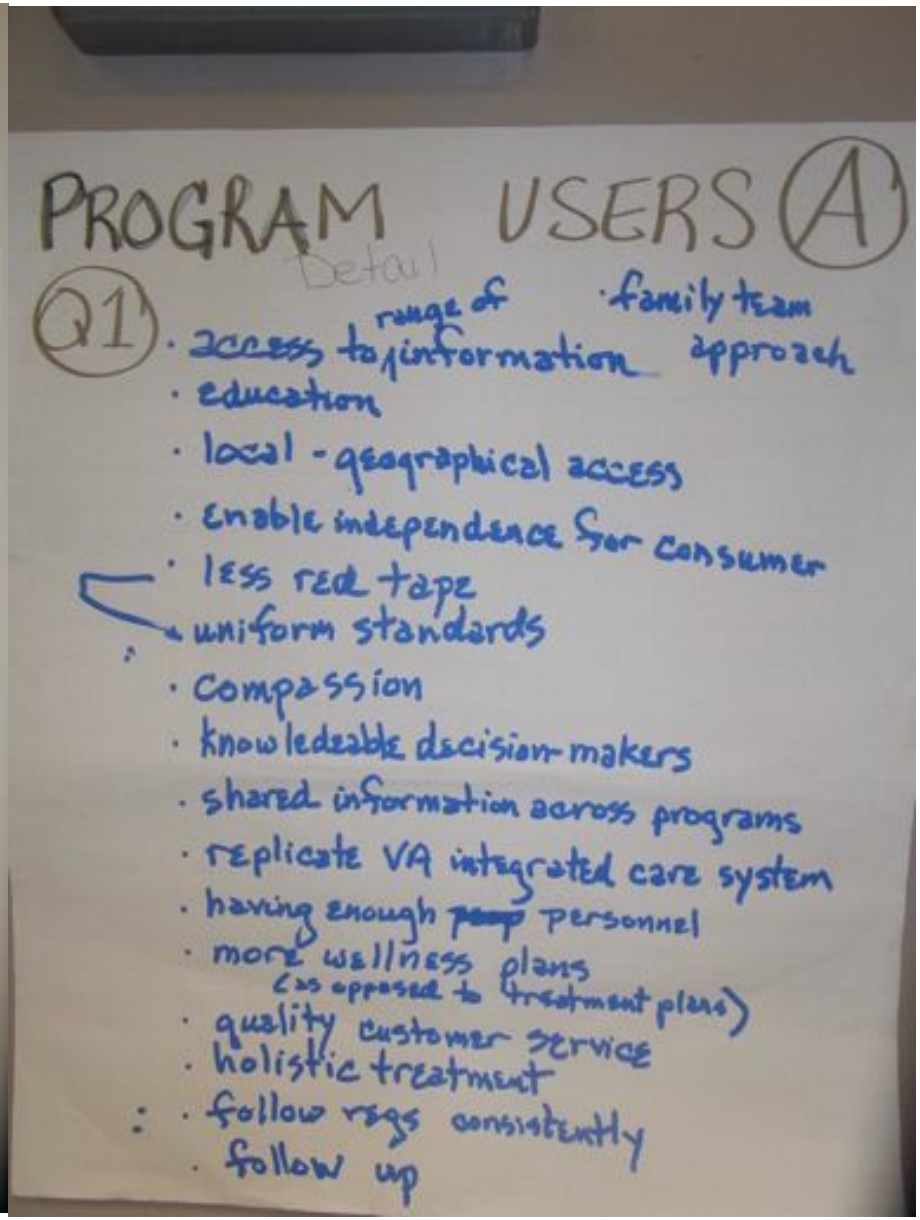
- Eligibility process is a nightmare and no access until found eligible. Can take 6 months to a year.
- Adequate reimbursement for everyone.
- Case Manager oversight provided by DHHS – someone watching them.
- Providers need fair and equitable reimbursement
- Clear guidelines for providers and less red tape
- Access to a comprehensive set of services so that they can make appropriate referrals
- Sufficient state and federal funding
- Fair and adequate funding
- Face to face appeals based on care improvement
- Adequate compensation
- Client care coordination with a team approach
- Consumer input and responsibility – look at what they need and want
- Communication between state and providers (specifically regarding Medicare rules and regulations)
- Community capacity to provide services

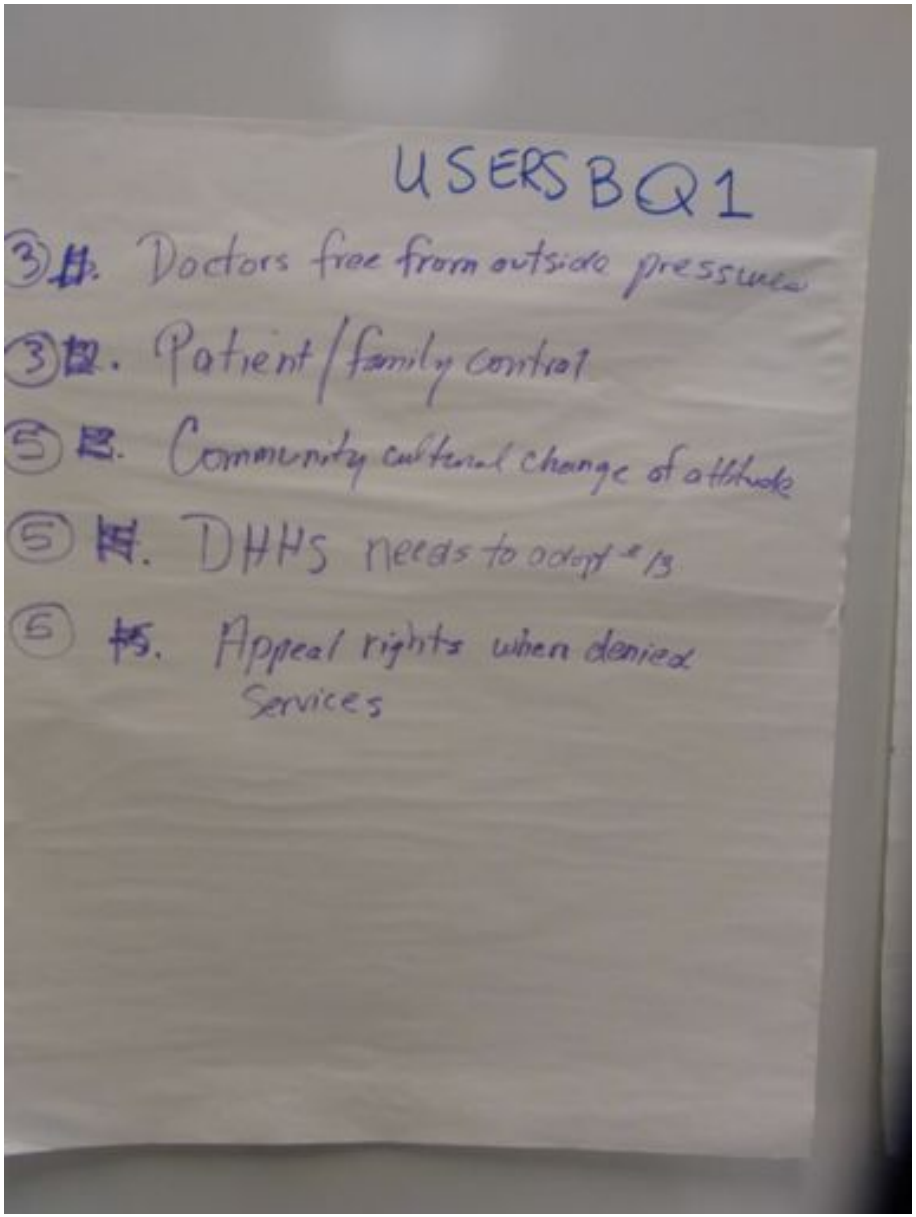
Program User Perspective - Exercise 1

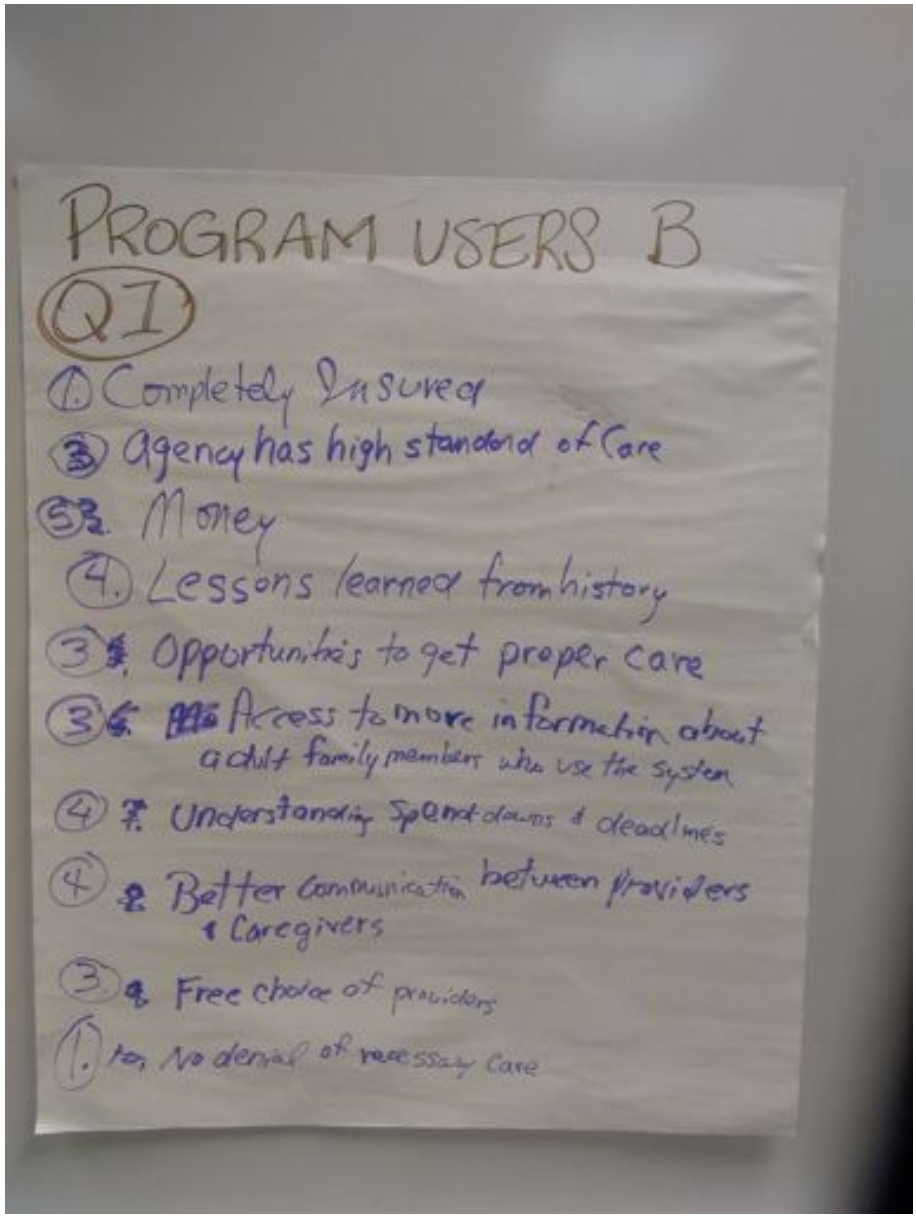
What's needed to increase # with high quality of life/health?

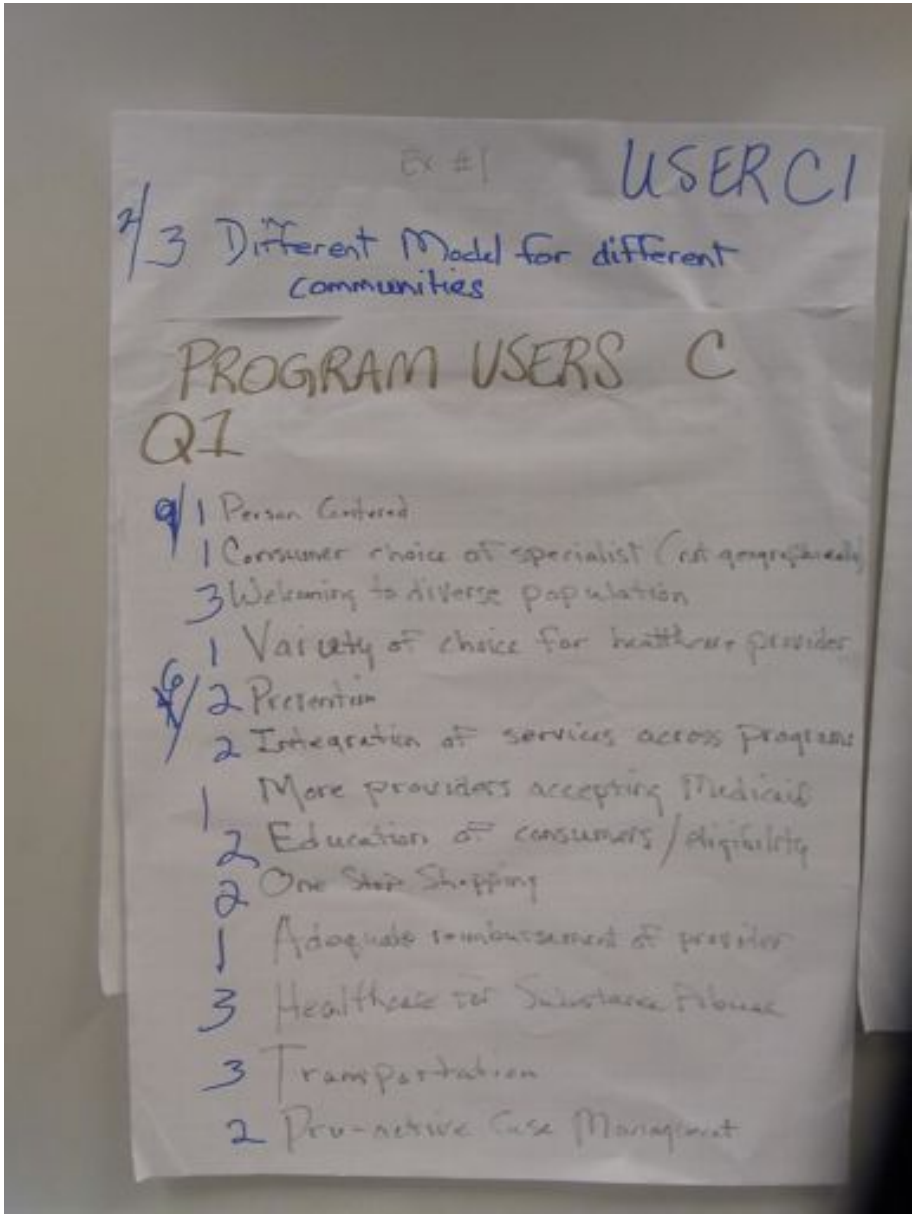


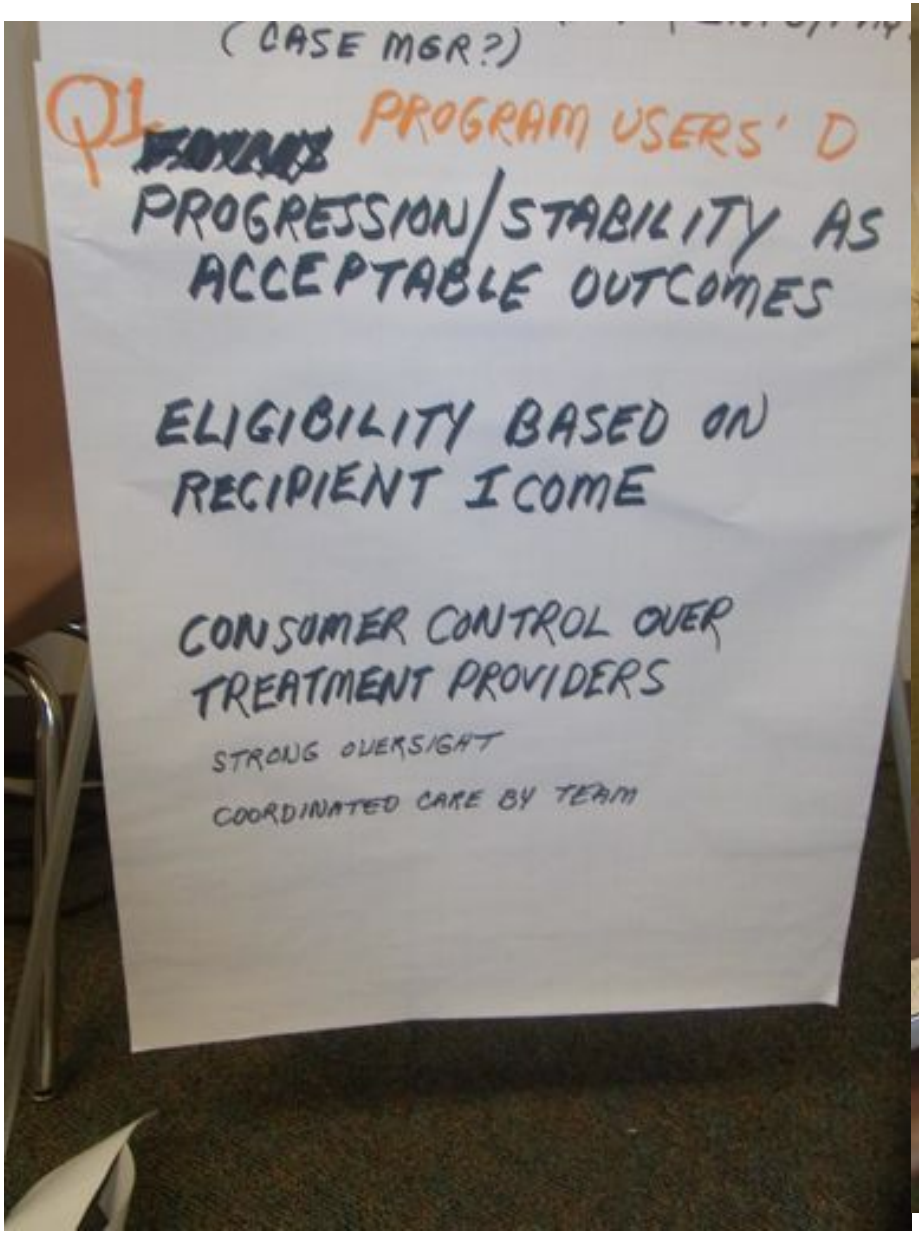

Q1 Summarized USERSA Q1
5 1 Access to range of info- geographically easy
5 2 Consistent standards consistently implemented across systems
3 Integrated, holistic, family/team (VA) approach
4 Qual. customer service / follow up / enough personnel
5 Wellness vs treatment / independent choices
2 6 Consumer-centered providers

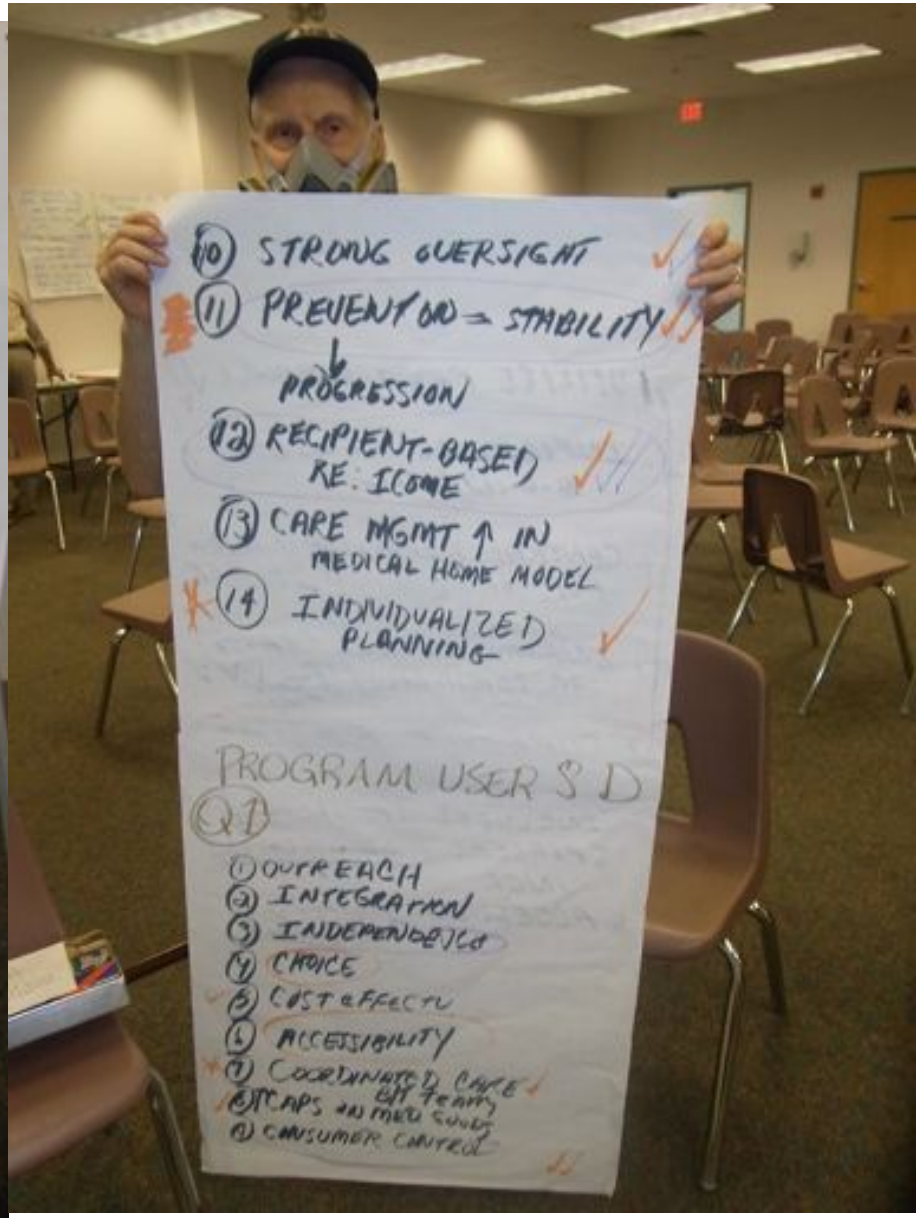

PROGRAM USERS A
Detail
Q1
· access to information range of
· family team approach
· education
· local - geographical access
· enable independence for consumer
· less red tape
· uniform standards
· compassion
· knowledgable decision-makers
· shared information across programs
· replicate VA integrated care system
· having enough personnel
· more wellness plans (as opposed to treatment plans)
· quality customer service
· holistic treatment
· follow regs consistently
· follow up


USERS B Q1
3 11. Doctors free from outside pressures
3 12. Patient/family control
5 13. Community cultural change of attitude
5 14. DHHS needs to adopt #13
5 15. Appeal rights when denied Services


PROGRAM USERS B
Q1
1. Completely Insured
3 Agency has high standard of Care
5 2. Money
4. Lessons learned from history
3 3. Opportunities to get proper care
3 6 16 Access to more information about adult family members who use the system
4 7. Understanding Spend downs & deadlines
4 8. Better Communication between providers & Caregivers
3 9. Free choice of providers
1 10. No denial of necessary care

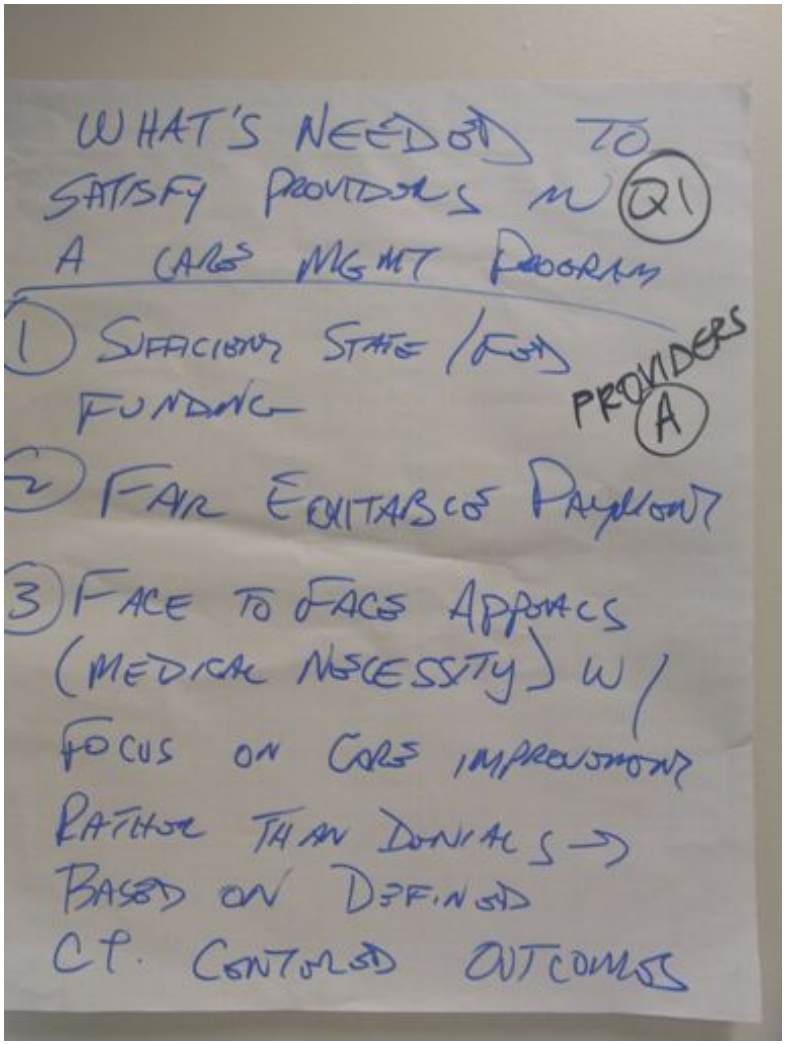

Ex #1
USER C1
3/3 Different Model for different communities
PROGRAM USERS C
Q1
9/1 Person Centered
1 Consumer choice of specialist (not geographically)
3 Welcoming to diverse population
1 Variety of choice for healthcare provider
6/2 Prevention
2 Integration of services across programs
1 More providers accepting Medicaid
2 Education of consumers / eligibility
2 One Stop Shopping
1 Adequate reimbursement of provider
3 Healthcare for Substance Abuse
3 Transportation
2 Pro-active Case Management

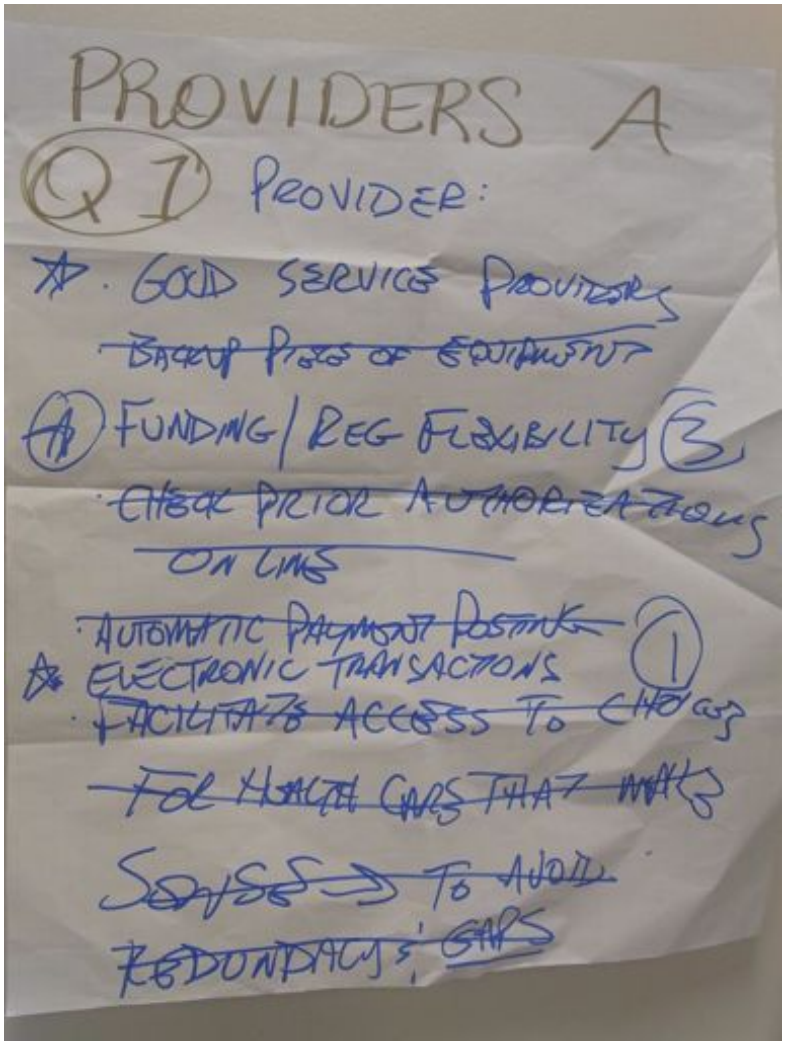

(CASE MGR?)
Q1
PROGRAM USERS' D
PROGRESSION/STABILITY AS ACCEPTABLE OUTCOMES
ELIGIBILITY BASED ON RECIPIENT ICOME
CONSUMER CONTROL OVER TREATMENT PROVIDERS
STRONG OVERSIGHT
COORDINATED CARE BY TEAM

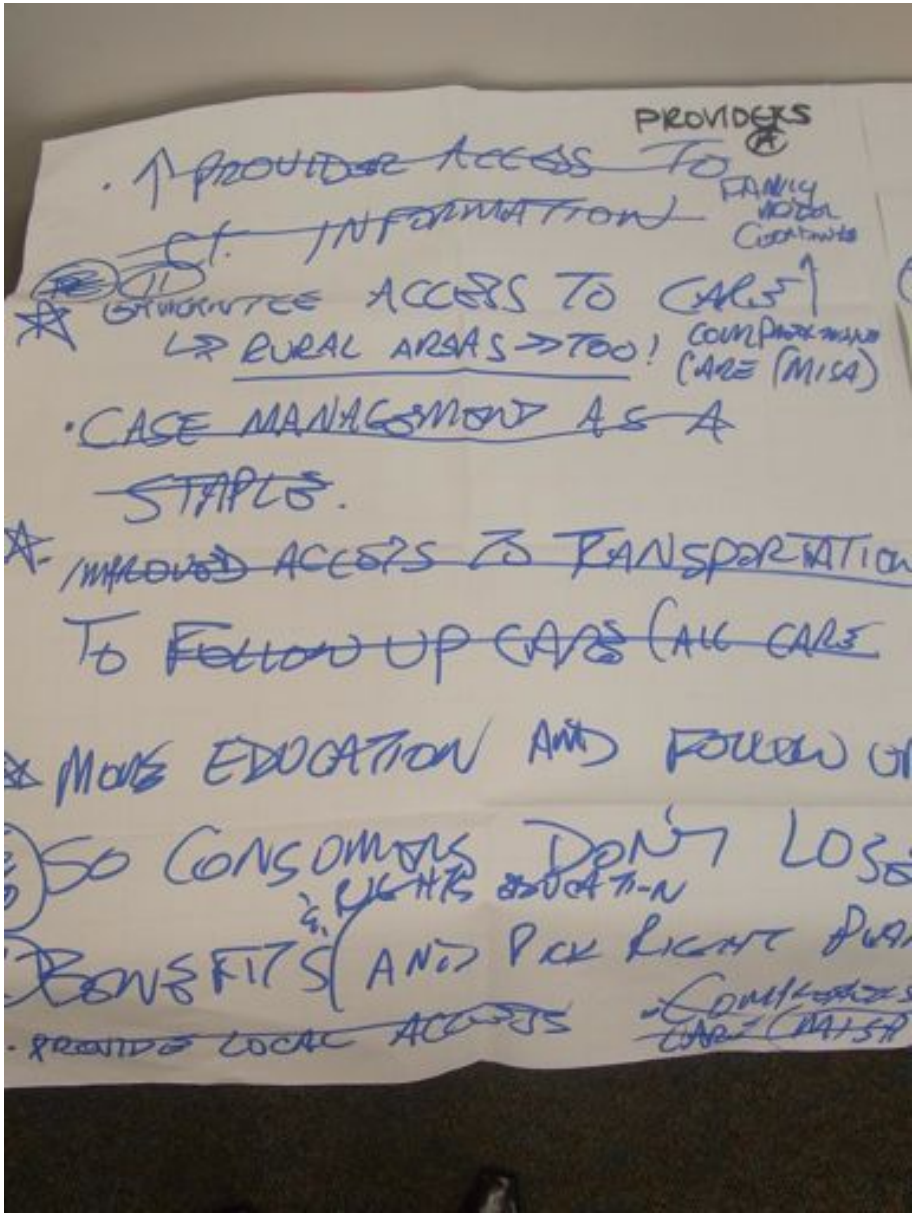

(10) STRONG OVERSIGHT
(11) PREVENTION → STABILITY
PROGRESSION
(12) RECIPIENT-BASED RE: ICOME
(13) CARE MGMT ↑ IN MEDICAL HOME MODEL
(14) INDIVIDUALIZED PLANNING
PROGRAM USER'S D
Q1
(1) OUTREACH
(2) INTEGRATION
(3) INDEPENDENCE
(4) CHOICE
(5) COST EFFECTIV
(6) ACCESSIBILITY
(7) COORDINATED CARE BY TEAM
(8) CAPS ON MED COSTS
(9) CONSUMER CONTROL

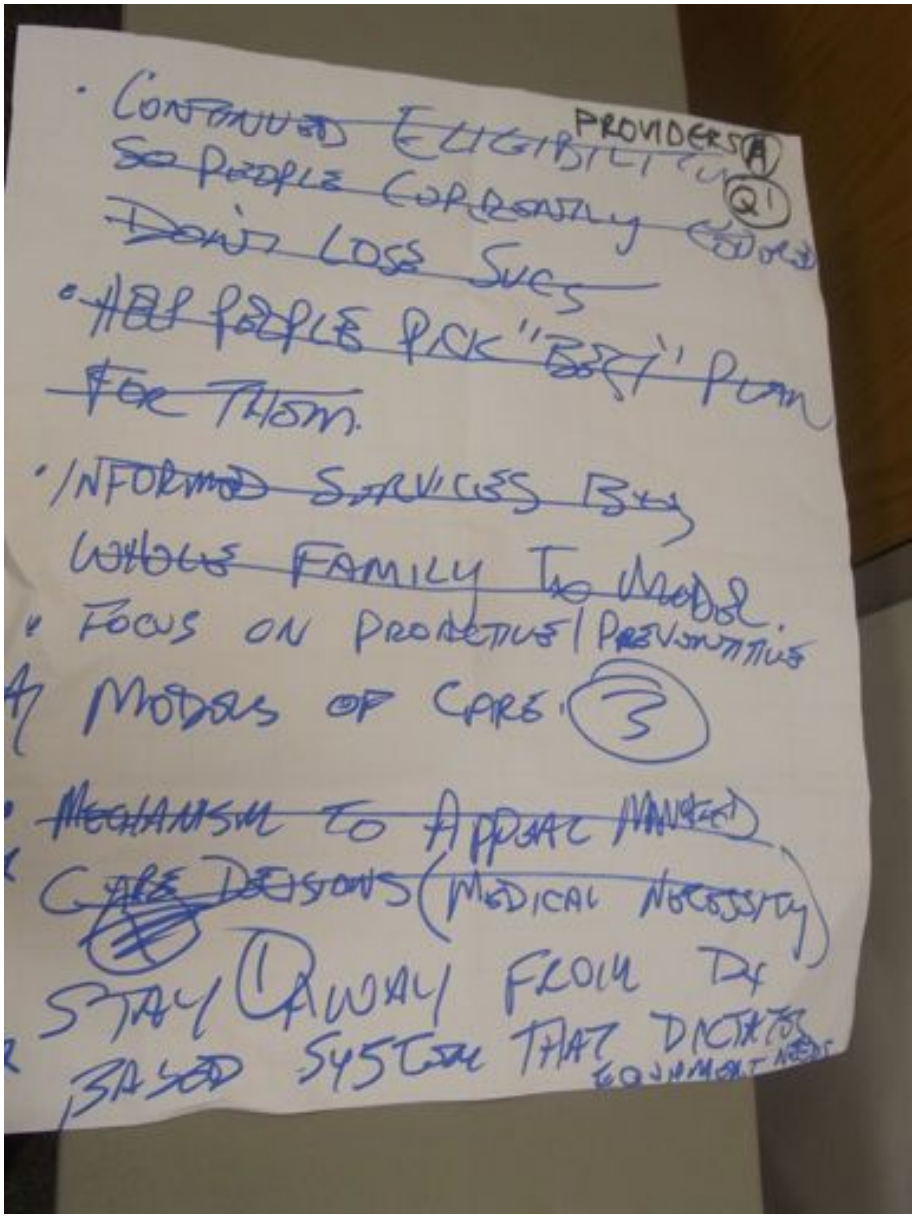
Provider Perspective – Exercise 1

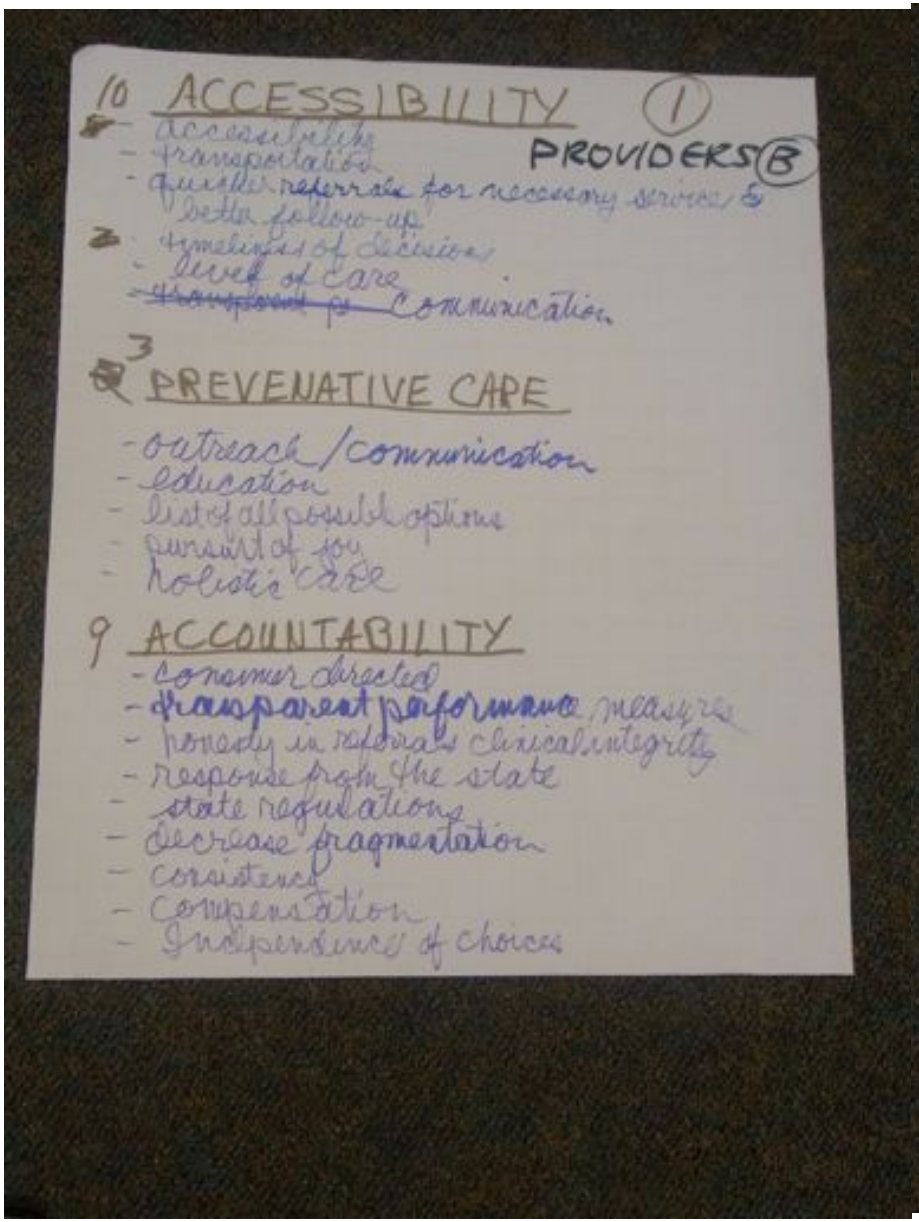
What's needed to increase # with high quality of life/health

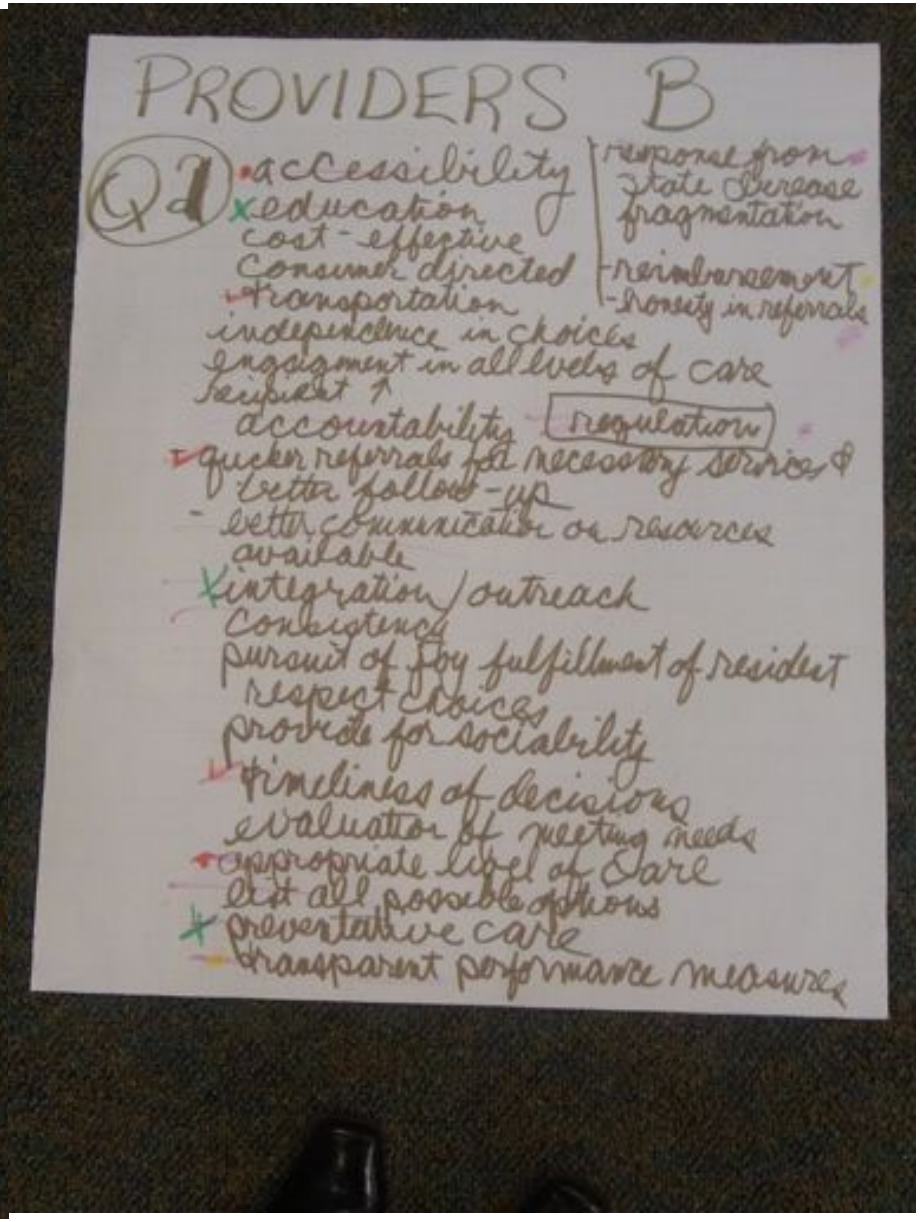


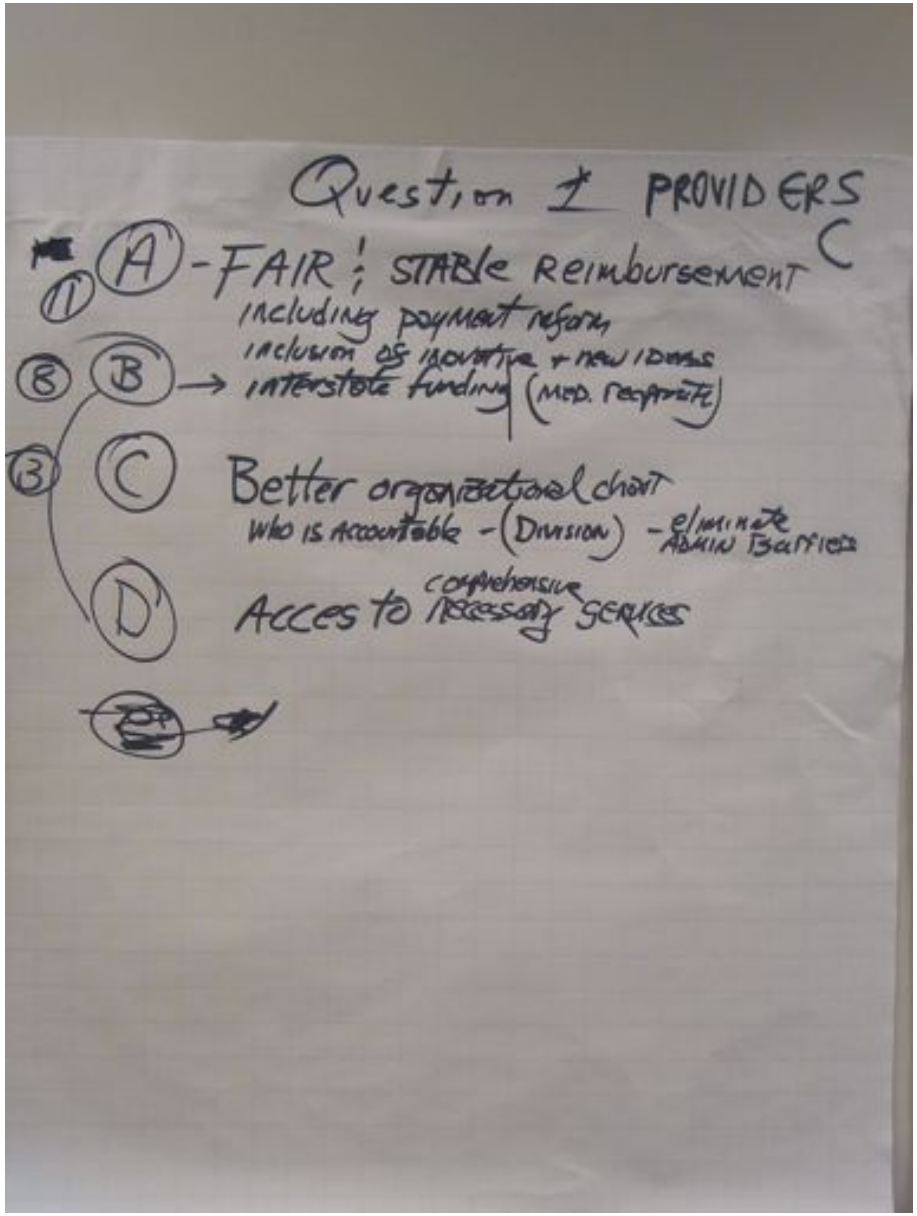


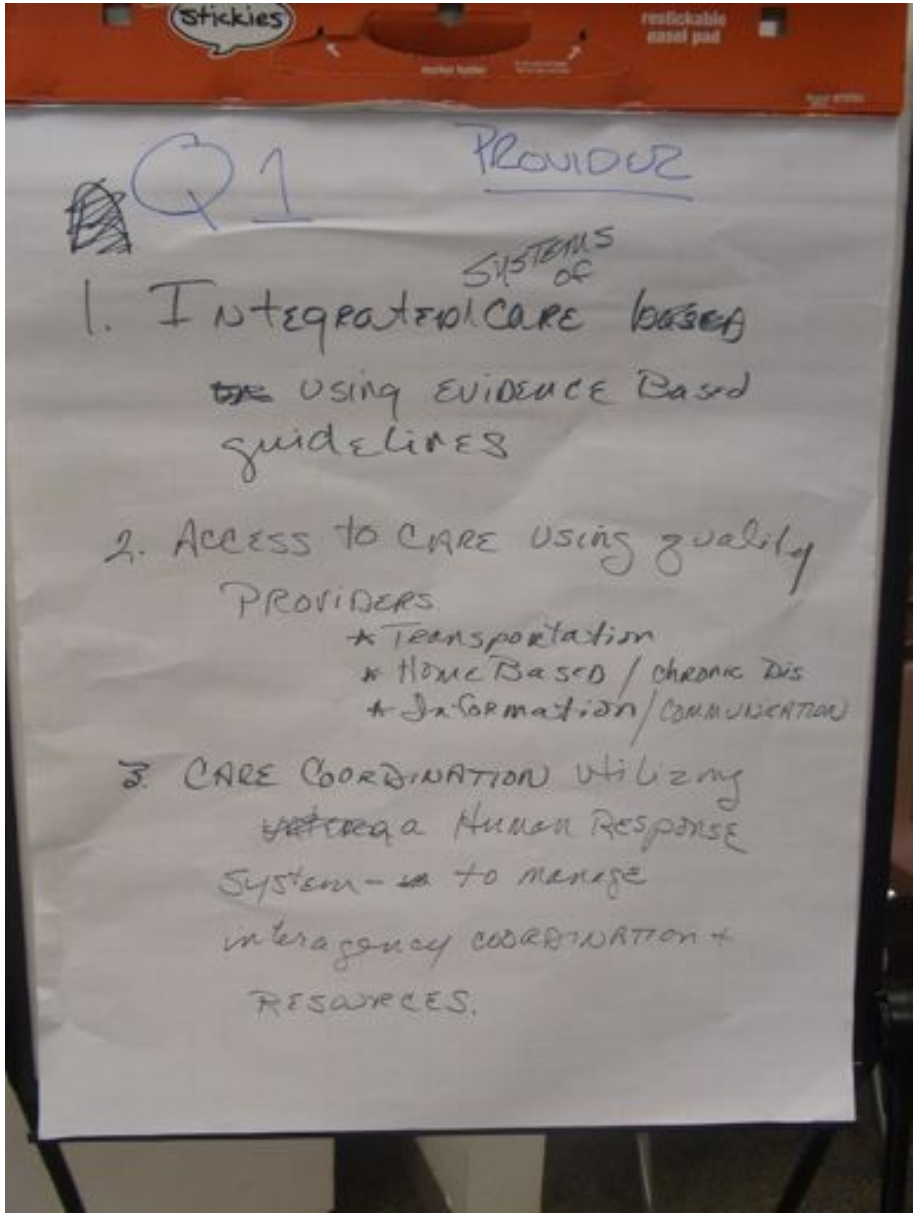

PROVIDERS
↑ PROVIDER ACCESS TO
INFORMATION
FAMILY
GUARANTEE ACCESS TO CARE
RURAL AREAS → TOO!
CASE MANAGEMENT AS A
STAPLE.
TO FOLLOW UP CARE
MORE EDUCATION AND
BENEFITS
PROVIDE LOCAL ACCESS

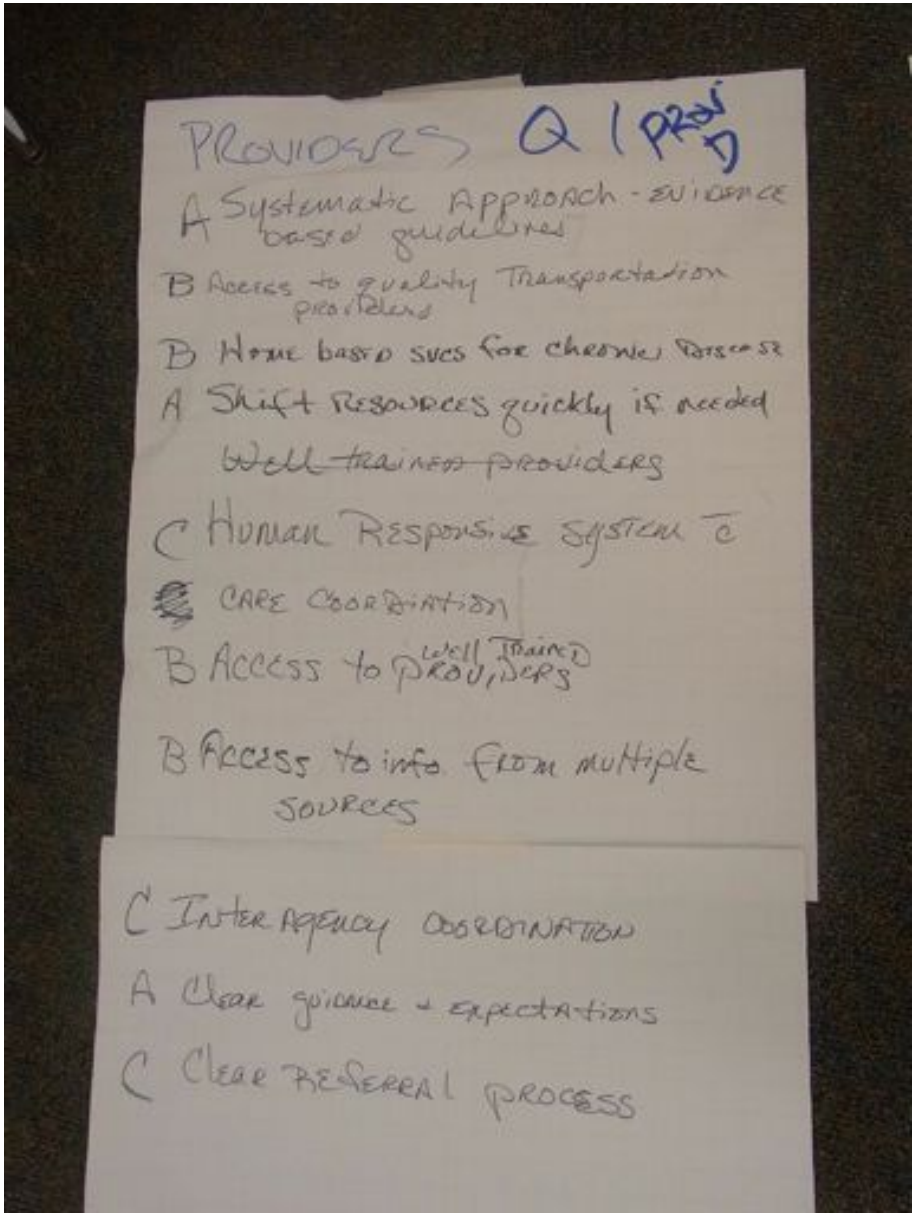

PROVIDERS
Q1
DON'T LOSE SVCS
FOR THEM.
FOCUS ON PROACTIVE/PREVENTATIVE
MODELS OF CARE.
3
MEDICAL NECESSITY
STAY AWAY FROM THE
BASED SYSTEM THAT

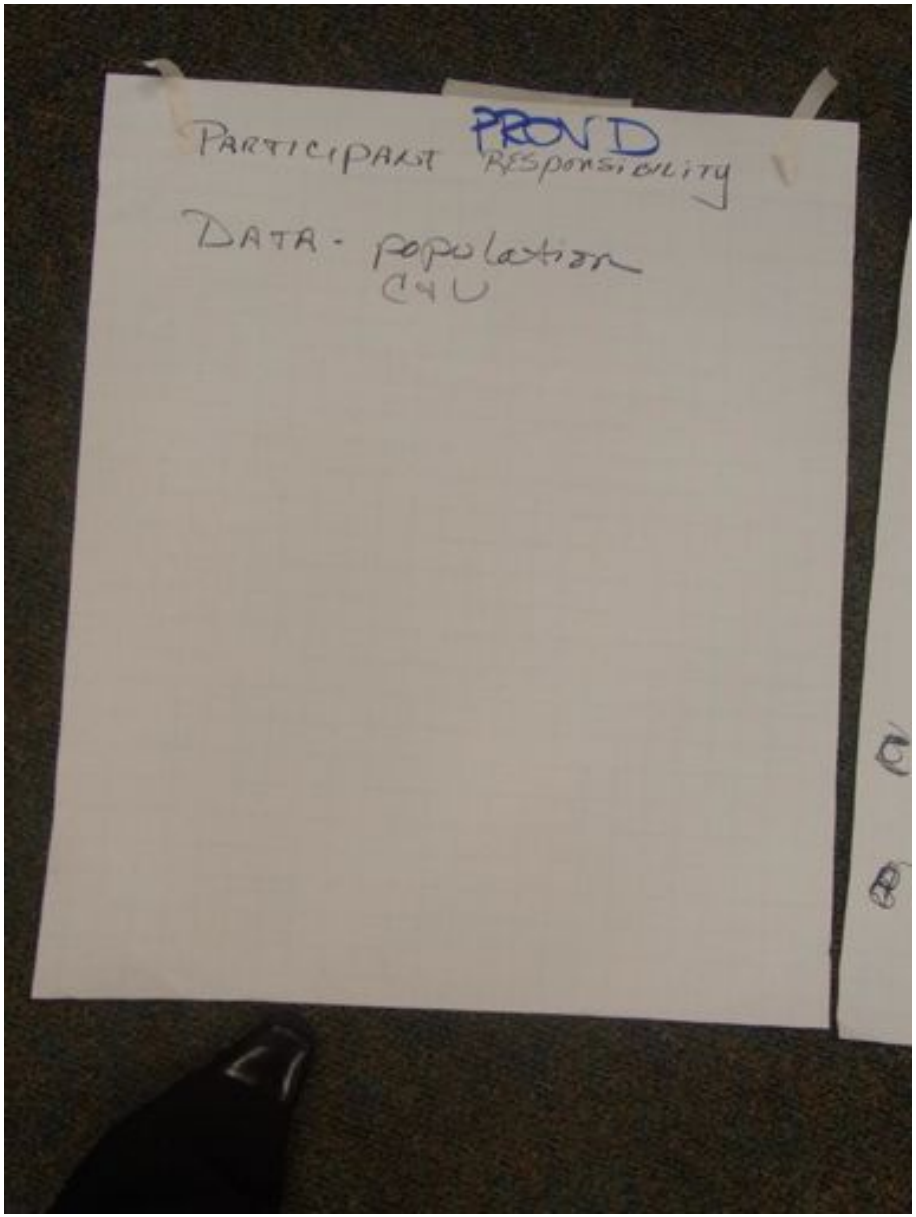

10 ACCESSIBILITY (1)
PROVIDERS (B)
- accessibility
- transportation
- quicker referrals for necessary services & better follow-up
- timelines of decisions
- level of care
- communication
3 PREVENATIVE CARE
- outreach / communication
- education
- list of all possible options
- pursuit of joy
- holistic care
9 ACCOUNTABILITY
- consumer directed
- transparent performance measures
- honesty in referrals clinical integrity
- response from the state
- state regulations
- decrease fragmentation
- consistency
- compensation
- independence of choices


PROVIDERS B
Q1
accessibility
education
cost-effective
consumer directed
transportation
independence in choices
engagement in all levels of care
recipient ↑
accountability
regulation
quicker referrals for necessary services & better follow-up
better communication on resources available
integration / outreach
consistency
pursuit of joy fulfillment of resident
respect choices
provide for sociability
timelines of decisions
evaluation of meeting needs
appropriate level of care
list all possible options
preventative care
transparent performance measures
response from state decrease fragmentation
reimbursement
honesty in referrals


Question 1 PROVIDERS
A - FAIR ; STABLE Reimbursement
including payment reform
B
inclusion of innovative + new ideas
interstate funding (MED. recipients)
C
Better organizational chart
Who is Accountable - (Division) - eliminate Admin Barriers
D
Access to comprehensive necessary SERVICES

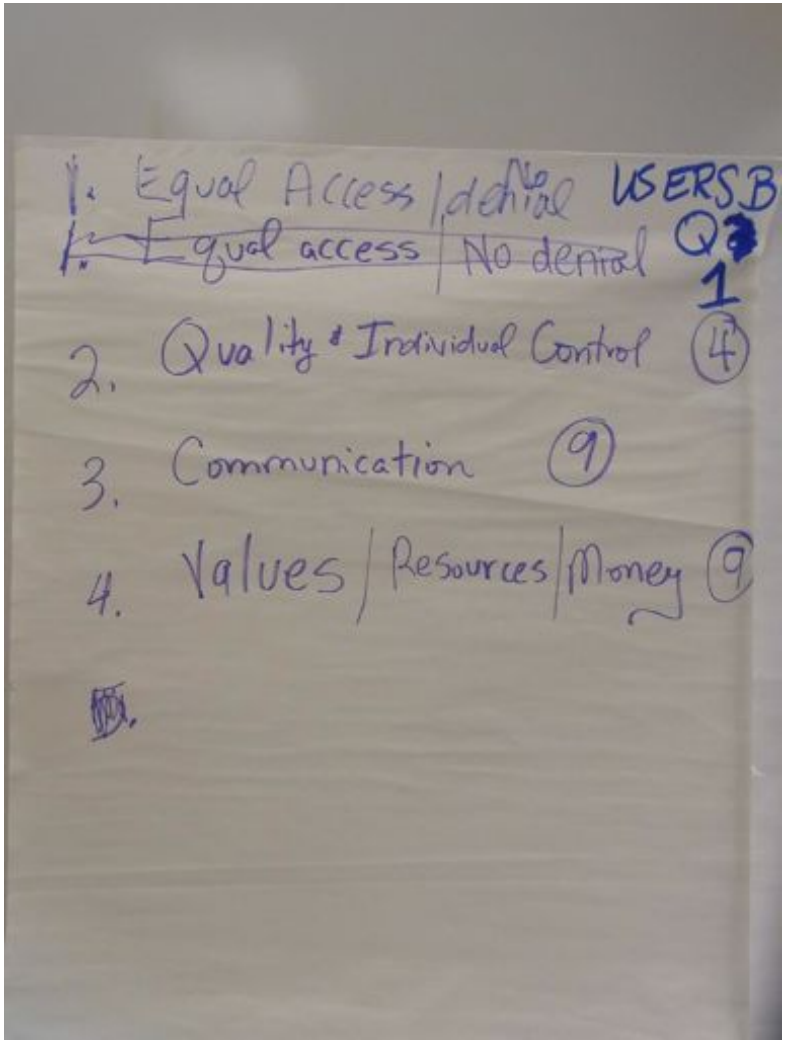

Stickies
Q 1
PROVIDER
1. INTEGRATED SYSTEMS OF CARE BASED USING EVIDENCE BASED GUIDELINES
2. ACCESS TO CARE USING QUALITY PROVIDERS
* Transportation
* Home Based / Chronic Dis
* Information / Communication
3. CARE COORDINATION utilizing a Human Response System - to manage interagency COORDINATION + RESOURCES.

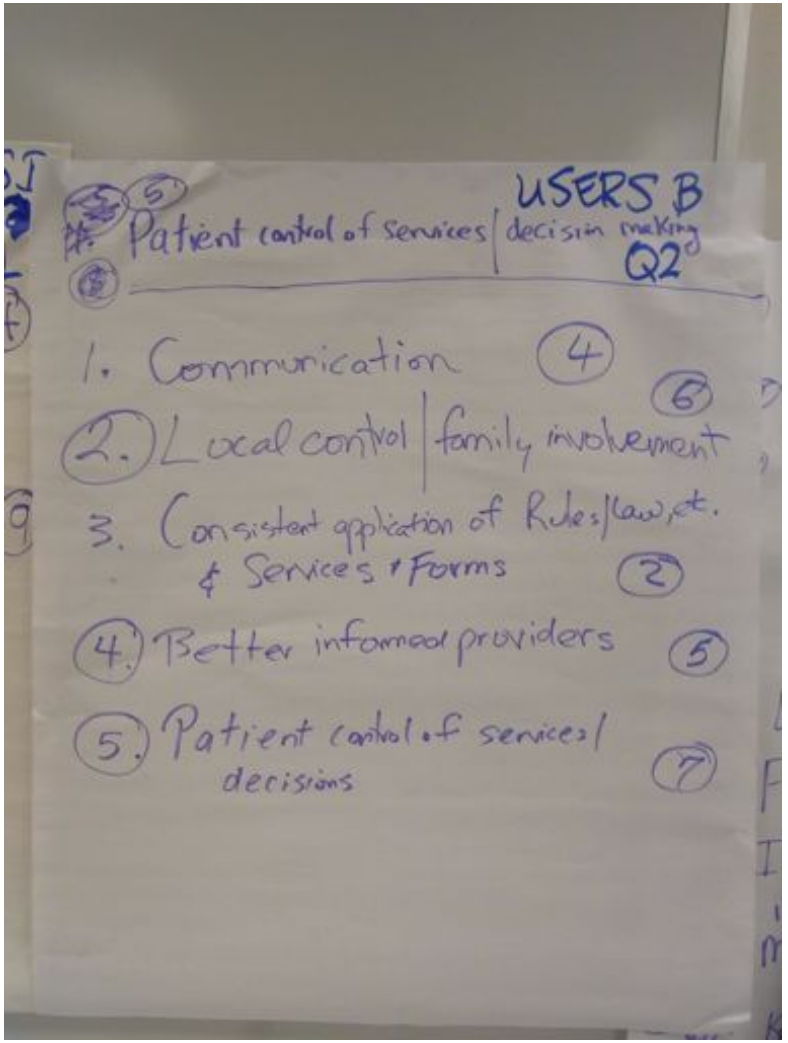

PROVIDERS Q 1 PROV
A Systematic Approach - evidence based guidelines
B Access to quality Transportation providers
B Home based svcs for chronic diseases
A Shift Resources quickly if needed
Well trained providers
C Human Responsive System
CARE COORDINATION
B Access to Well Trained PROVIDERS
B Access to info from multiple sources
C Inter Agency COORDINATION
A Clear guidance + expectations
C Clear REFERRAL process

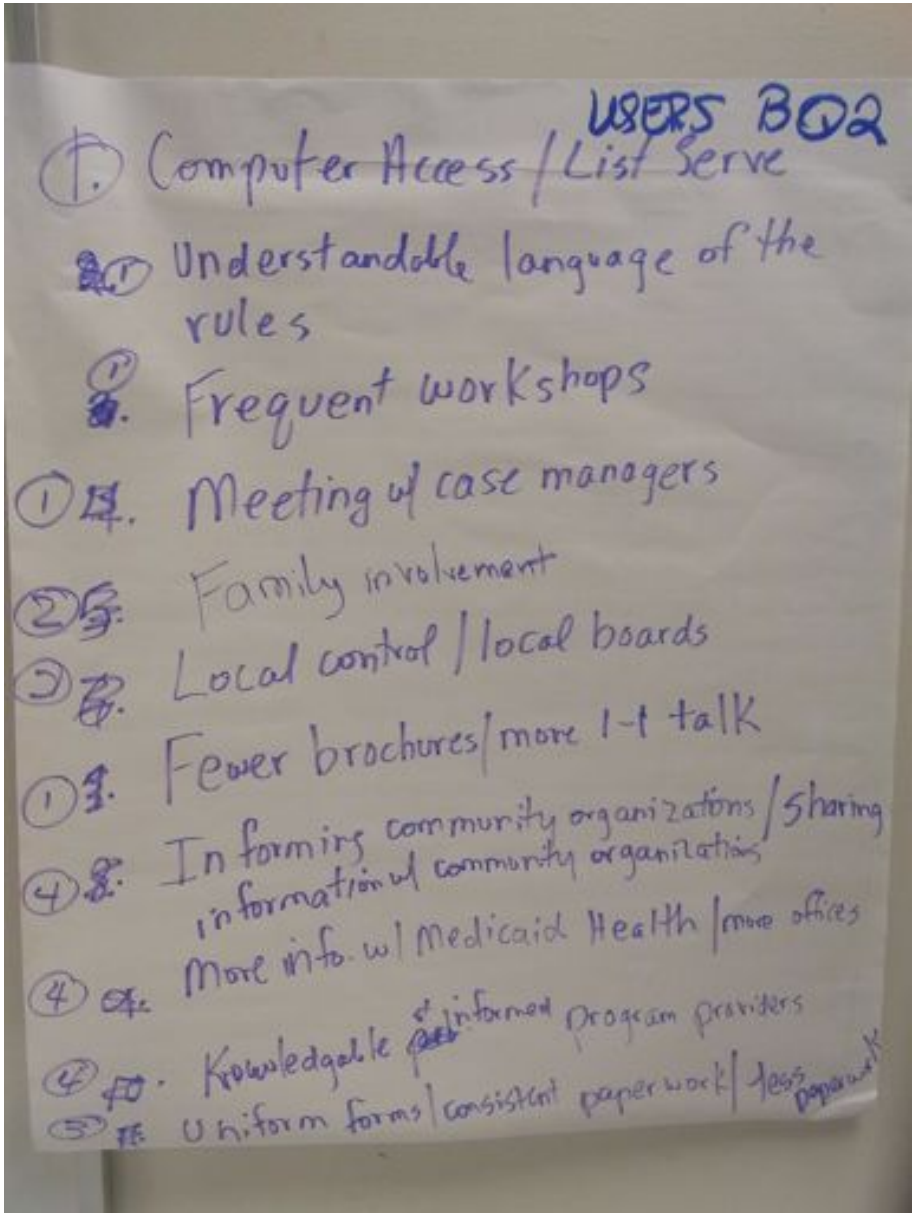

PARTICIPANT
PROVD
RESPONSIBILITY
DATA - population
CAU

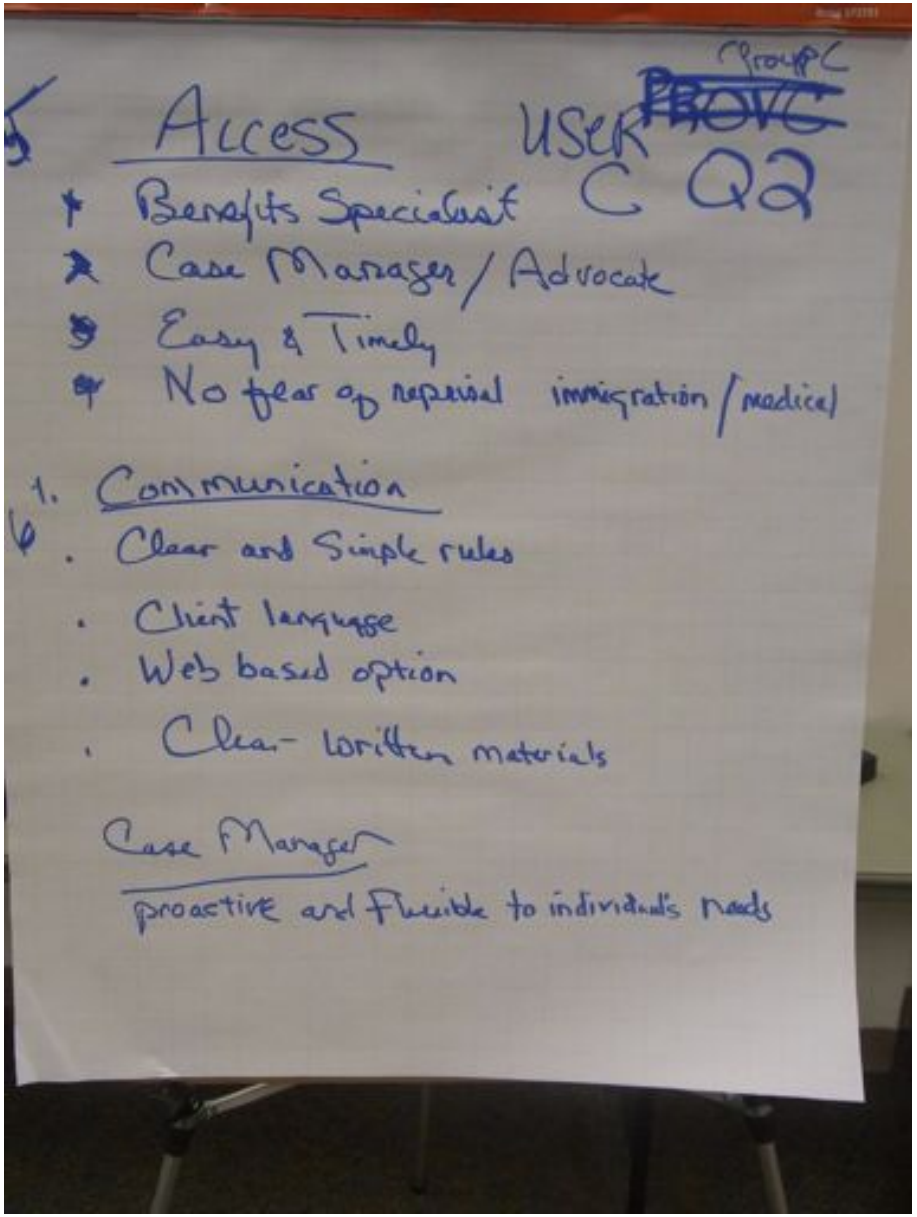
Program User Perspective – Exercise 2

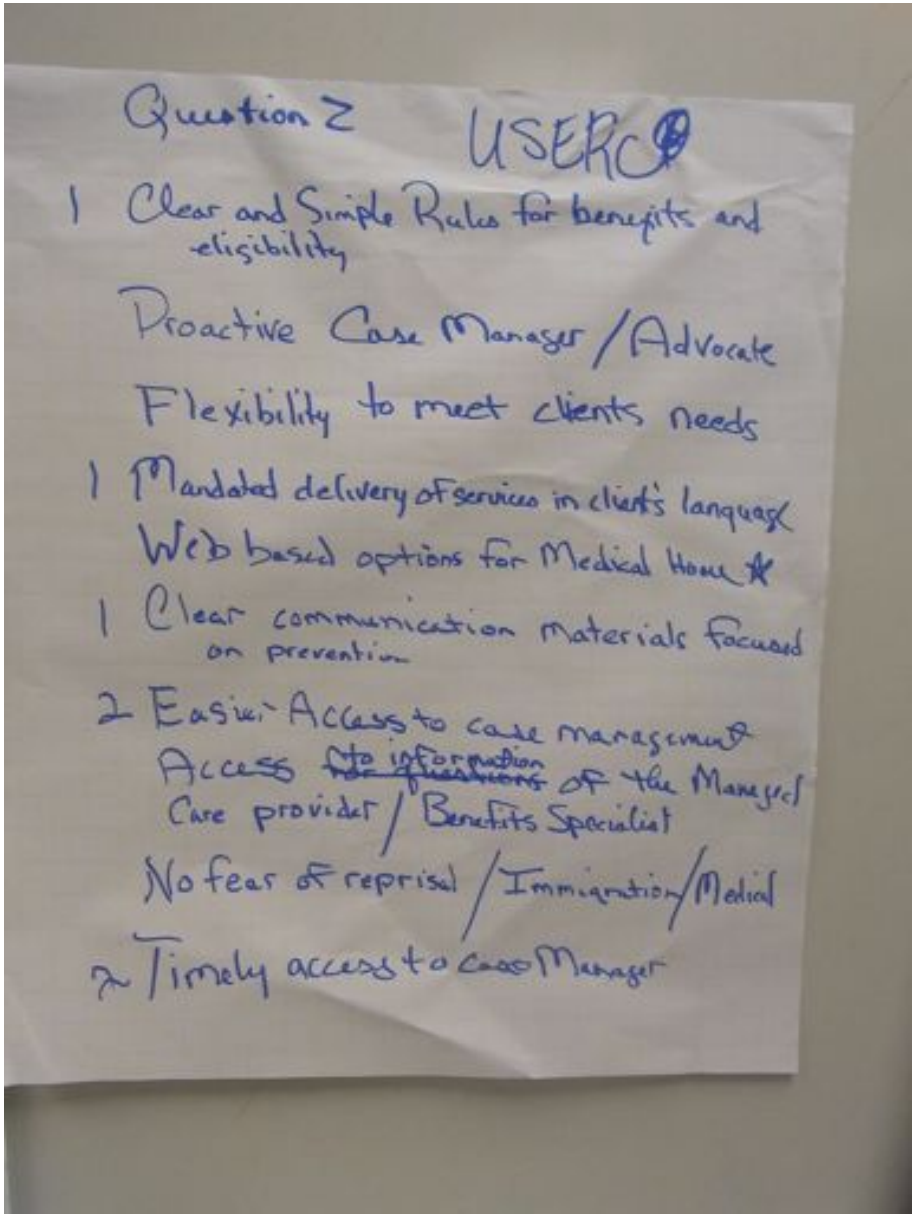
In a care management program, what must happen in order to create **knowledgeable and informed** recipients?

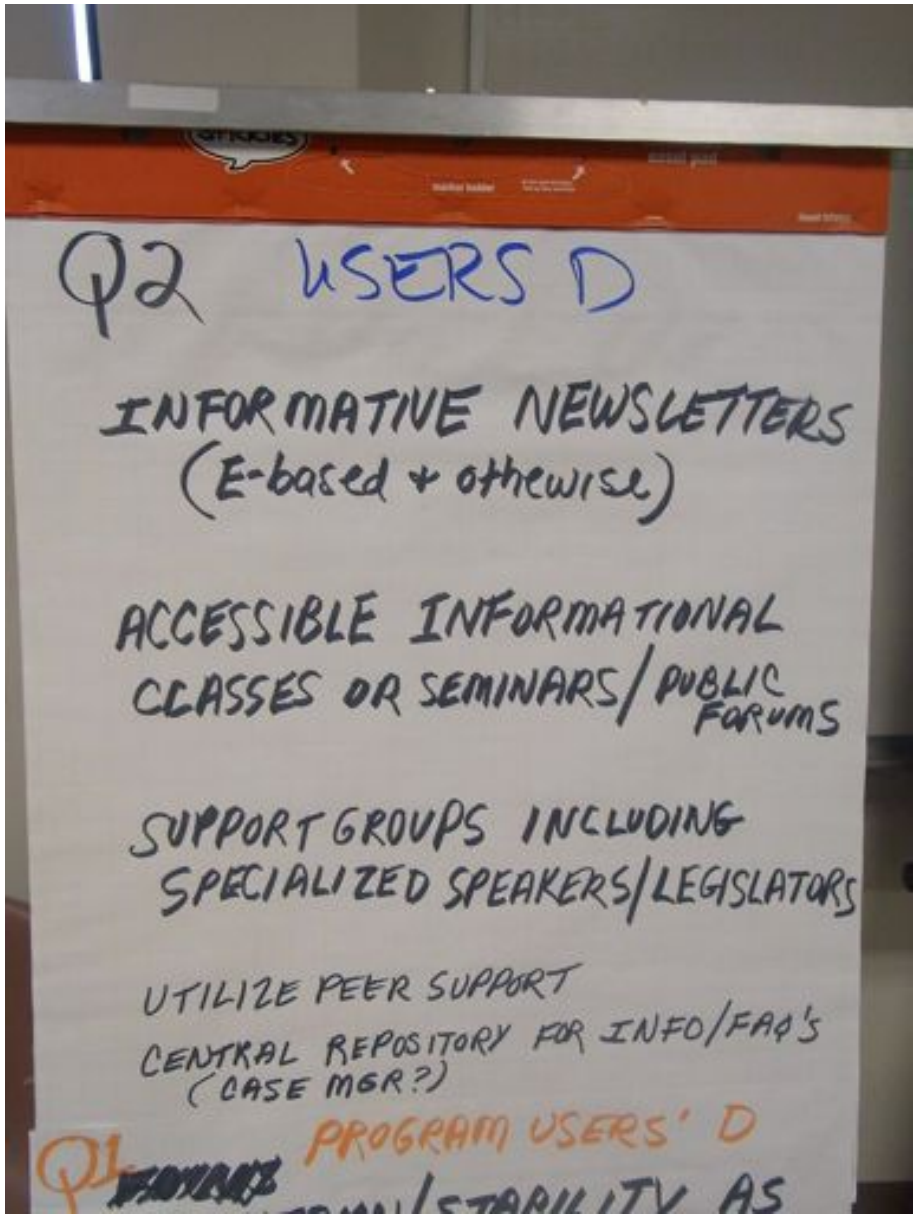


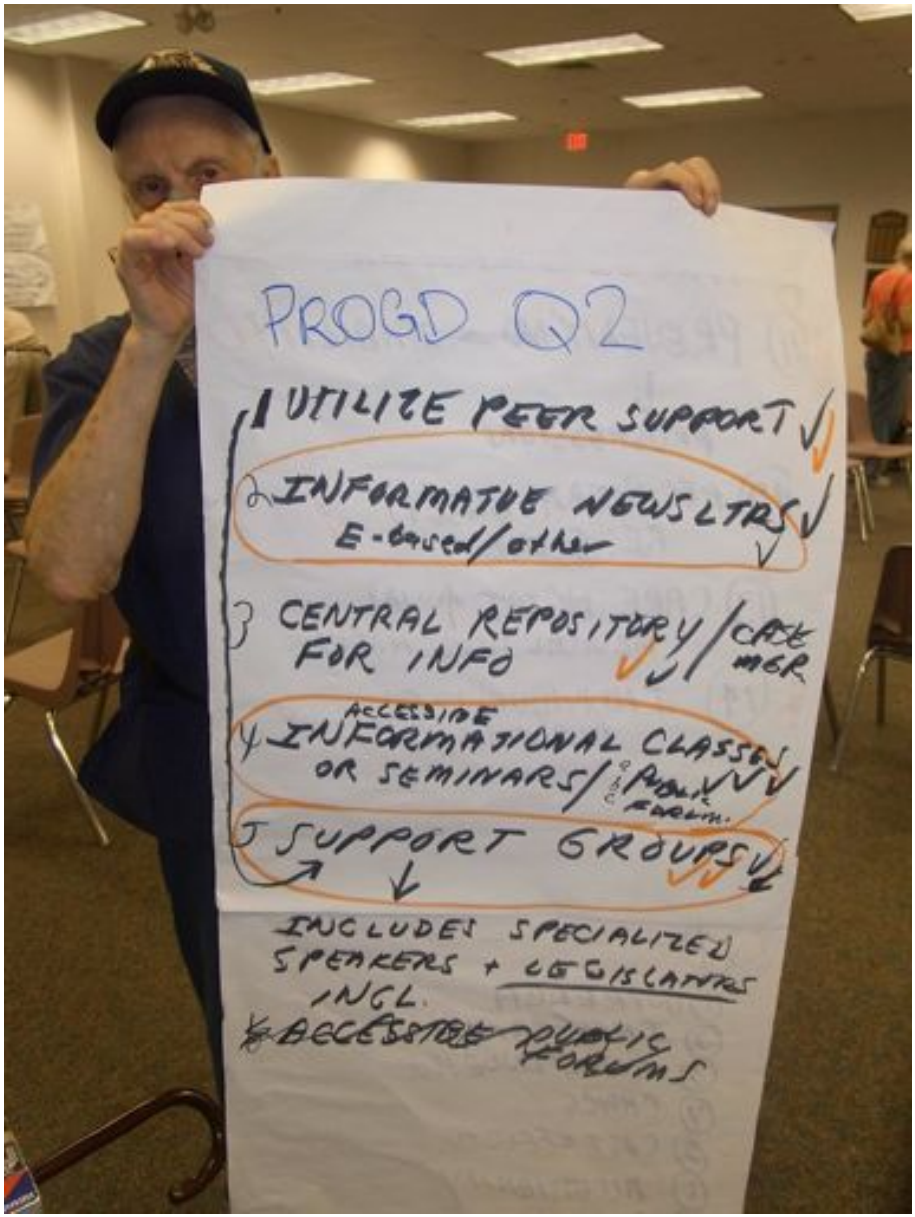



USERS BOX
1. Computer Access / List Serve
2. Understandable language of the rules
3. Frequent workshops
4. Meeting of case managers
5. Family involvement
6. Local control / local boards
7. Fewer brochures / more 1-1 talk
8. Informing community organizations / sharing informational community organizations
9. More info. w/ Medicaid Health / more offices
10. Knowledgable & informed program providers
11. Uniform forms / consistent paperwork / less paperwork


Group C
Access
USER C Q2
Benefits Specialist
Case Manager / Advocate
Easy & Timely
No fear of reprisal immigration / medical
1. Communication
. Clear and Simple rules
. Client language
. Web based option
. Clear written materials
Case Manager
proactive and flexible to individual's needs

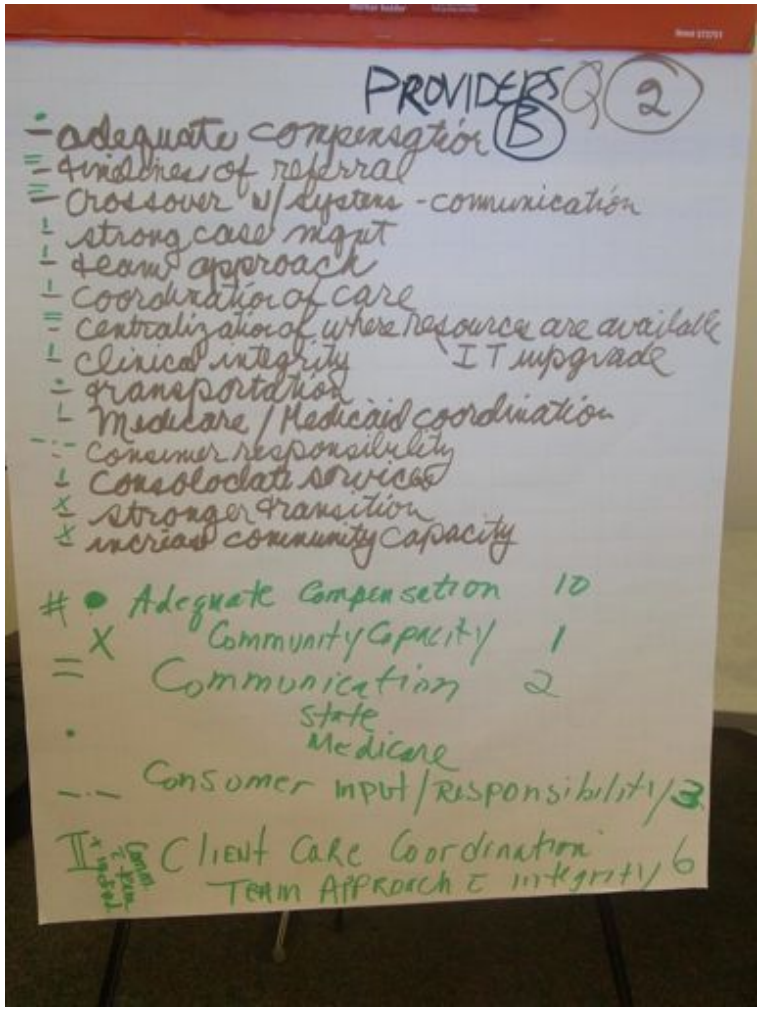

Question 2
USER C
1 Clear and Simple Rules for benefits and eligibility
Proactive Case Manager / Advocate
Flexibility to meet clients needs
1 Mandated delivery of services in client's language
Web based options for Medical Home
1 Clear communication materials focused on prevention
2 Easier Access to case management
Access to information of the Managed Care provider / Benefits Specialist
No fear of reprisal / Immigration / Medical
2 Timely access to Case Manager

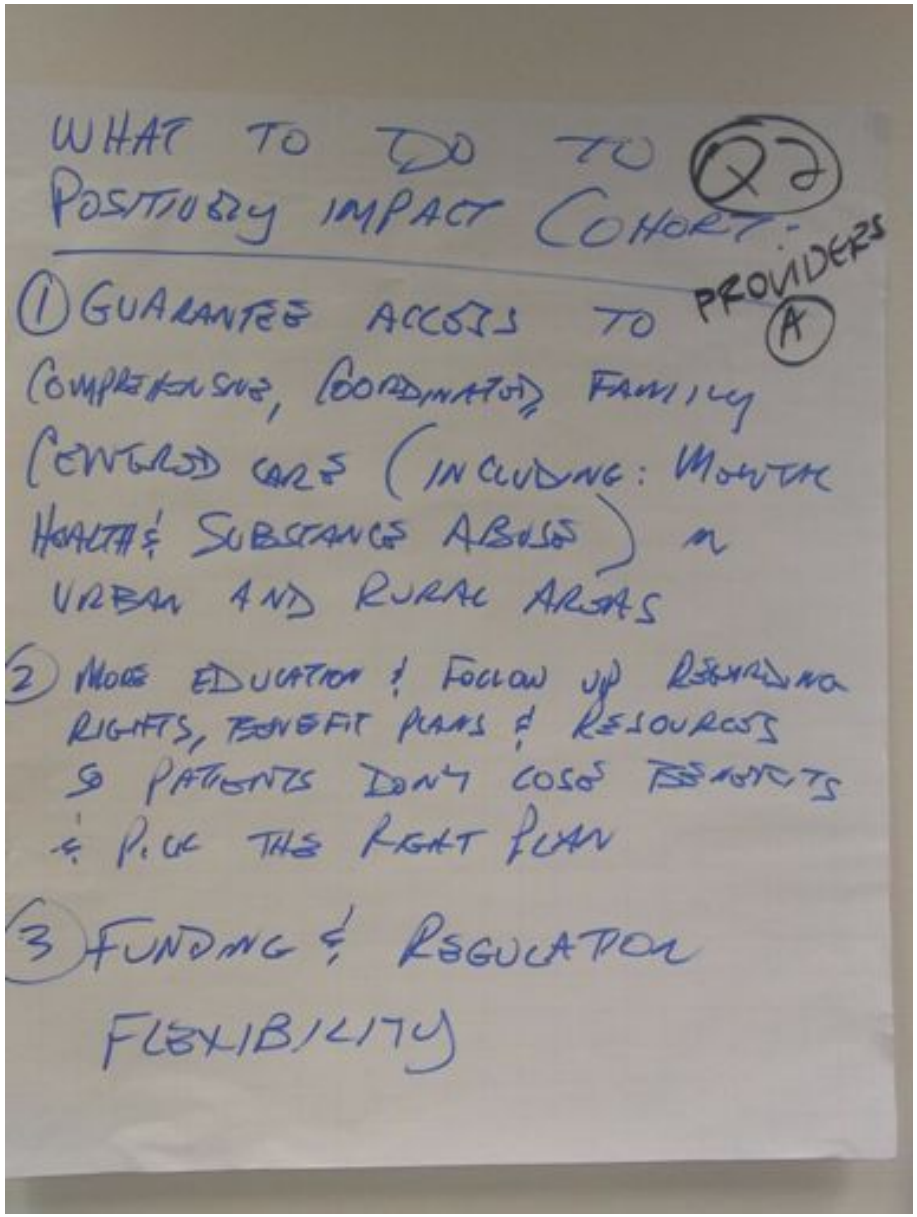

Q2 USERS D
INFORMATIVE NEWSLETTERS (E-based + otherwise)
ACCESSIBLE INFORMATIONAL CLASSES OR SEMINARS/PUBLIC FORUMS
SUPPORT GROUPS INCLUDING SPECIALIZED SPEAKERS/LEGISLATORS
UTILIZE PEER SUPPORT
CENTRAL REPOSITORY FOR INFO/FAQ's (CASE MGR?)
PROGRAM USERS' D

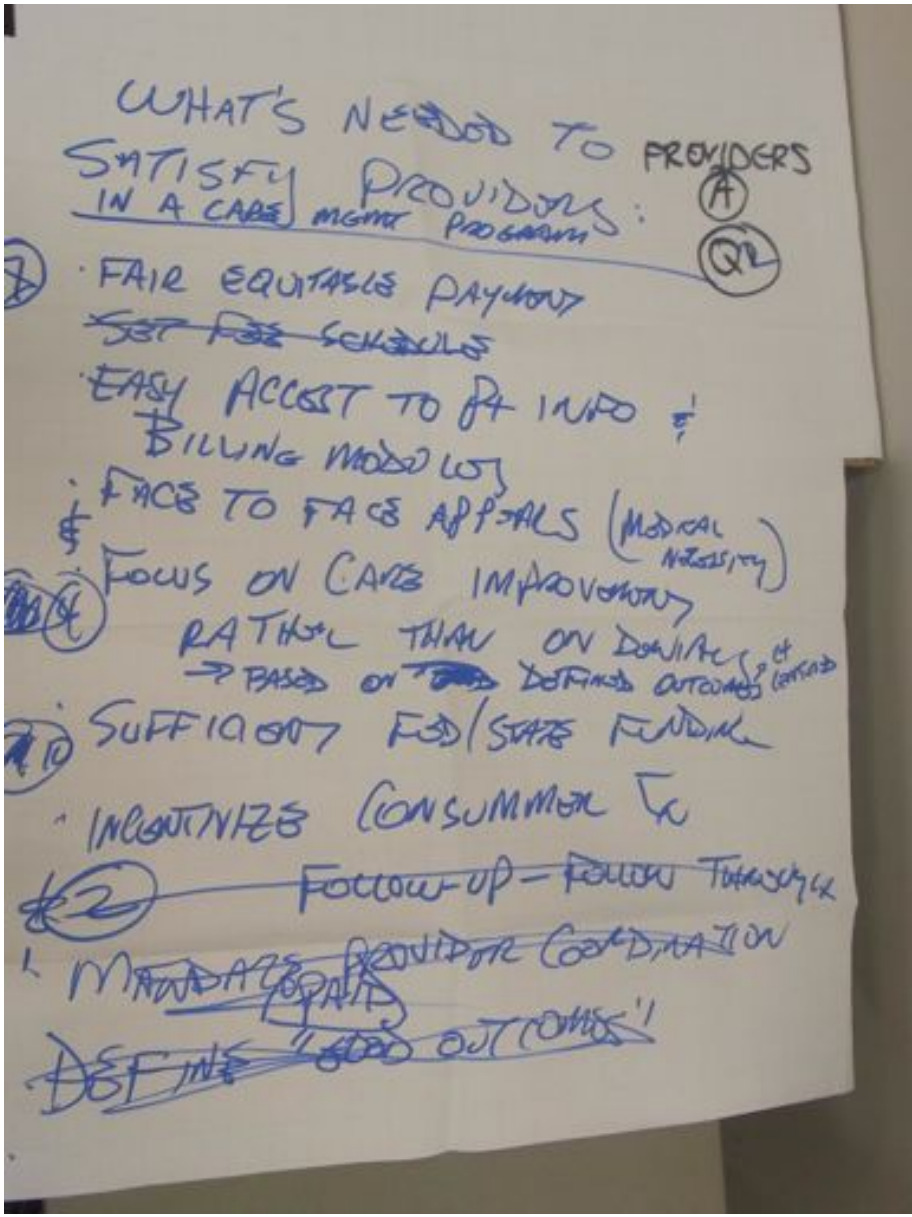

PROGD Q2
1 UTILIZE PEER SUPPORT
2 INFORMATIVE NEWSLTRS E-based/other
3 CENTRAL REPOSITORY FOR INFO / CASE MGR
4 ACCESSIBLE INFORMATIONAL CLASSES OR SEMINARS/ PUBLIC FORUMS
5 SUPPORT GROUPS
INCLUDES SPECIALIZED SPEAKERS + LEGISLATORS INCL.

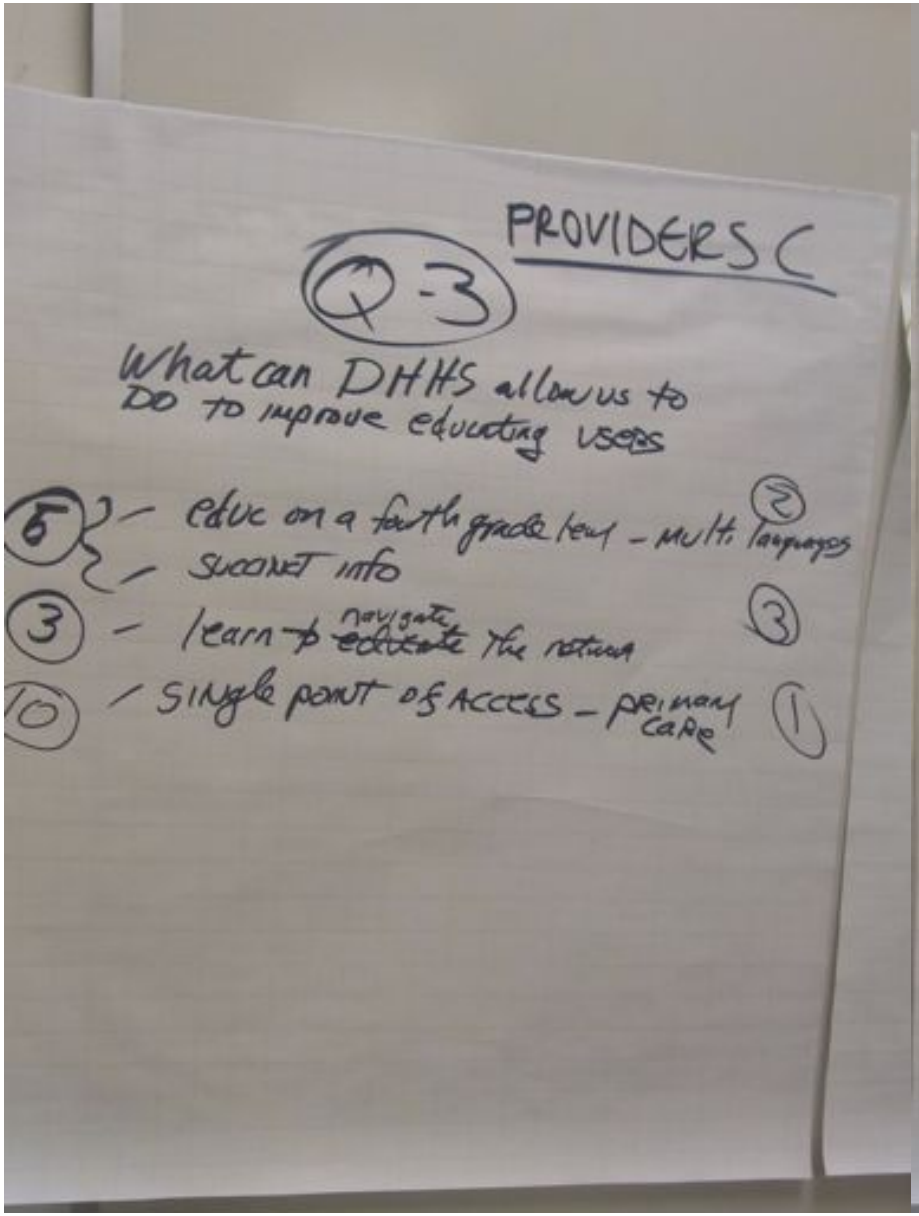
Provider Perspective – Exercise 2

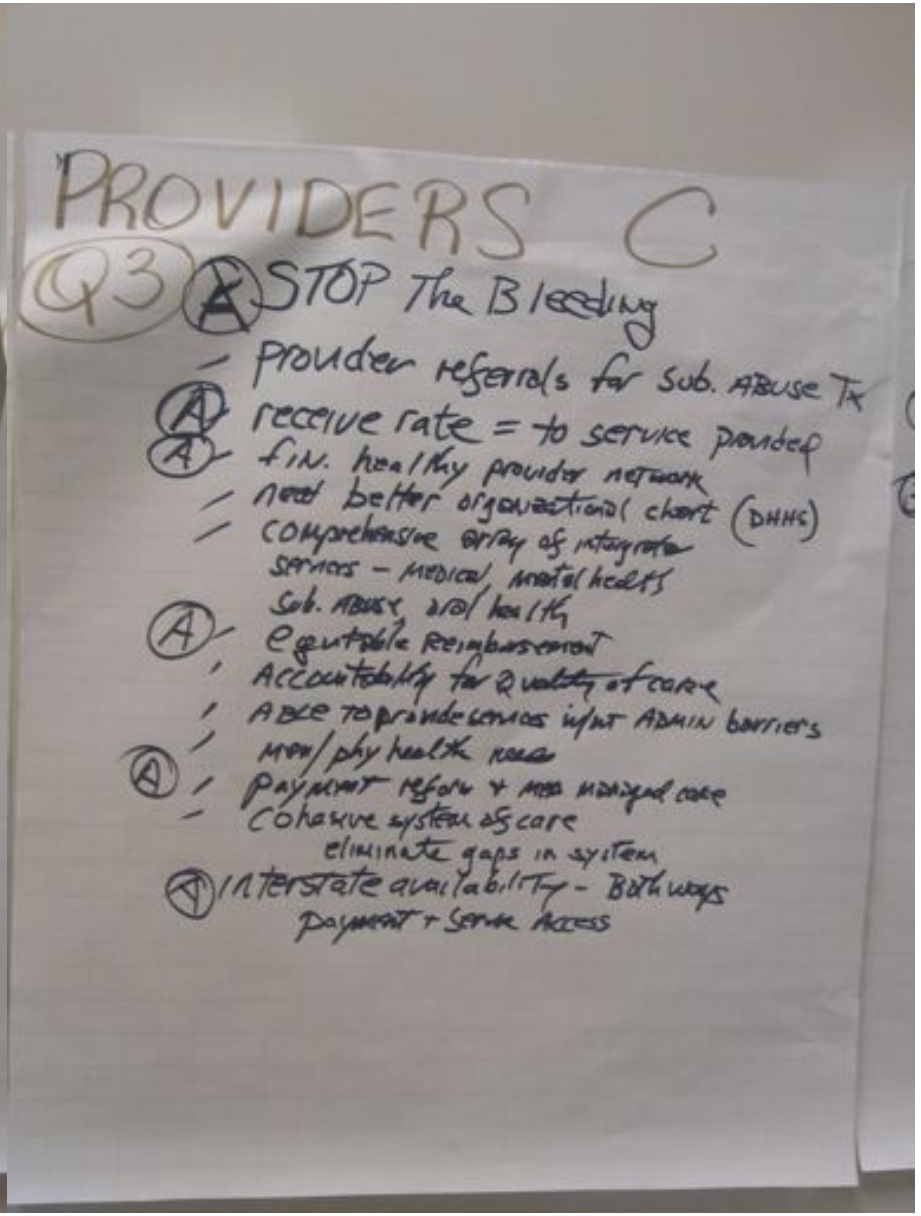
In a care management program, what must happen in order to **create satisfied providers** instead of dissatisfied (or **Resistant**) providers?

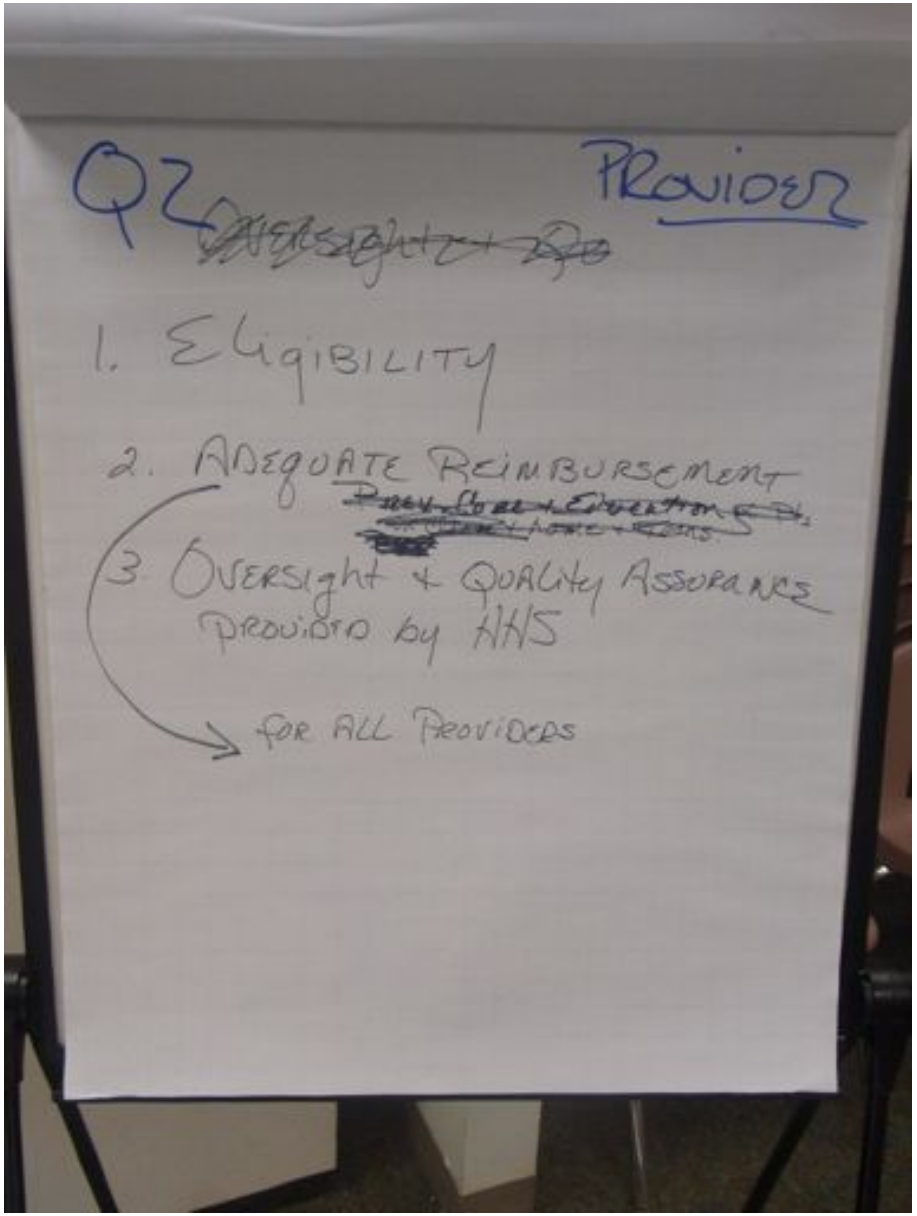


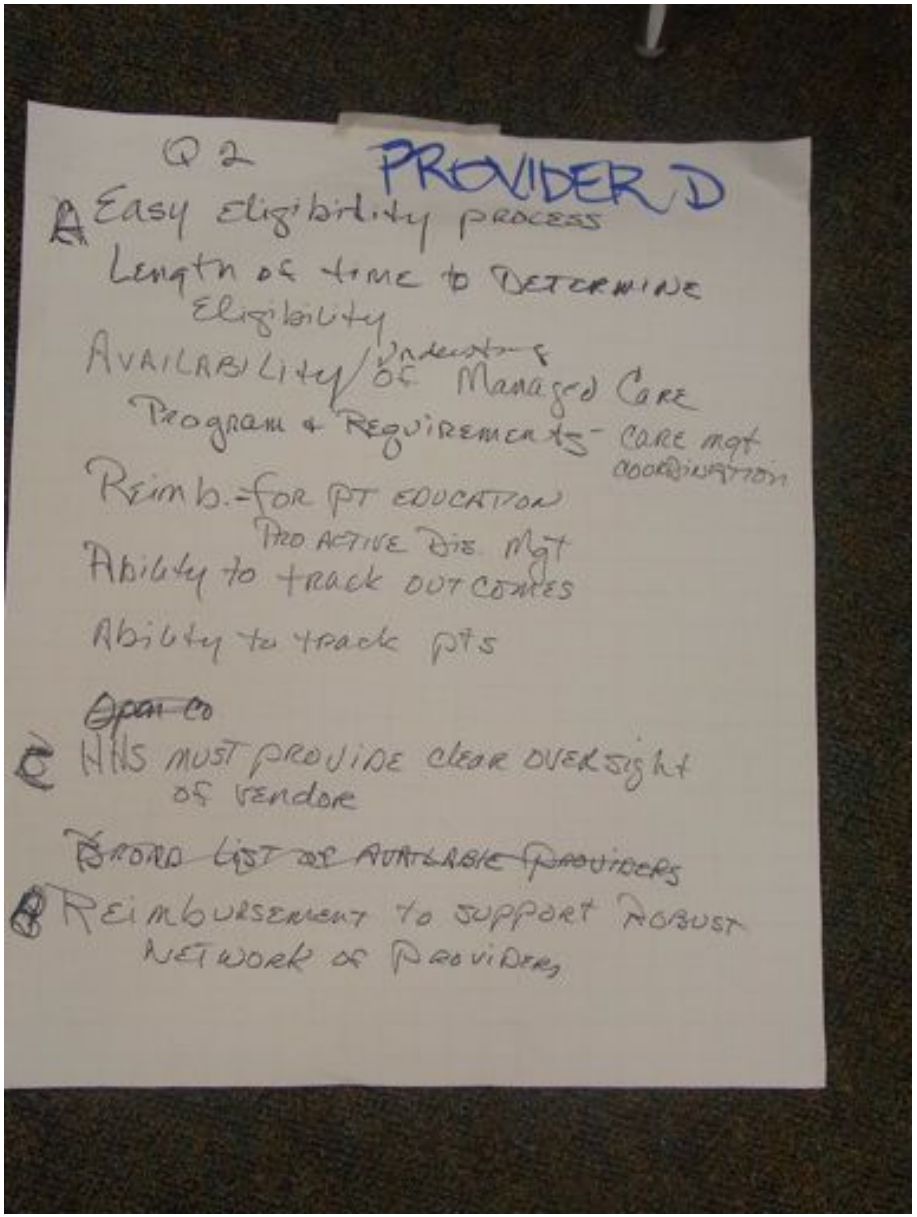

WHAT TO DO TO
POSITIVELY IMPACT COHORT:
Q2
PROVIDERS
A
1 GUARANTEE ACCESS TO COMPREHENSIVE, COORDINATED FAMILY CENTERED CARE (INCLUDING: MENTAL HEALTH & SUBSTANCE ABUSE) IN URBAN AND RURAL AREAS
2 MORE EDUCATION & FOLLOW UP REGARDING RIGHTS, BENEFIT PLANS & RESOURCES SO PATIENTS DON'T COSO BENEFITS & PICK THE RIGHT PLAN
3 FUNDING & REGULATORY FLEXIBILITY


WHAT'S NEEDED TO SATISFY PROVIDERS:
PROVIDERS
A
IN A CARE MGMT PROGRAM
Q2
· FAIR EQUITABLE PAYMENT
~~SET FEE SCHEDULE~~
· EASY ACCESS TO PT INFO & BILLING MODALITY
· FACE TO FACE APPEALS (MEDICAL NECESSITY)
· FOCUS ON CARE IMPROVEMENT RATHER THAN ON DOLLARS → BASED ON DEFINED OUTCOMES & CONTRACTS
· SUFFICIENT FED/STATE FUNDING
· INCENTIVIZE CONSUMER TO
~~FOLLOW-UP – FOLLOW THROUGH~~
MANDATE PROVIDER COORDINATION
~~DEFINE "GOOD OUTCOMES"~~


PROVIDERS C
Q-3
What can DHHS allow us to DO to improve educating users
5
- educ on a fourth grade level - multi languages
2
- succinct info
3
- learn to navigate the system
3
10
- single point of access - primary care
1


PROVIDERS C
Q3
A
STOP The Bleeding
- provider referrals for Sub. Abuse Tx
A
receive rate = to service provided
A
fin. healthy provider network
- need better organizational chart (DHHS)
- comprehensive array of integrated services - medical, mental health, Sub. Abuse, oral health
A
equitable reimbursement
- Accountability for quality of care
- Able to provide services w/out Admin barriers
- MH/phy health issues
A
- payment reform + more managed care
- Cohesive system of care
eliminate gaps in system
A
interstate availability - Both ways payment + service access


Q2
PROVIDERS
1. ELIGIBILITY
2. ADEQUATE REIMBURSEMENT
3 OVERSIGHT & QUALITY ASSURANCE PROVIDED BY HHS
FOR ALL PROVIDERS


Q 2
PROVIDERS
A Easy eligibility process
Length of time to DETERMINE Eligibility
AVAILABILITY/ of Managed Care
Program & Requirements - CARE mgt COORDINATION
Reimb. - FOR PT EDUCATION
PRO ACTIVE Dis. Mgt
Ability to track OUT COMES
Ability to track pts
C HHS MUST PROVIDE CLEAR OVERSIGHT of vendor
BROAD LIST OF AVAILABLE PROVIDERS
B REIMBURSEMENT TO SUPPORT ROBUST NETWORK OF PROVIDERS

NH Medicaid
Care Management Program
Public Forum

Concord, NH

September 29, 2011

Disclaimer

Please note that the comments and priorities that follow reflect the opinions of participating workgroups and not necessarily those of the Department of Health and Human Services.

Photos of charts reflect workgroup work process and product. Items crossed out typically reflect brainstormed suggestions that were combined with others.

Program Users Perspective - Exercise 1

What's needed to increase # with high quality of life/health?

- Integrated system in which all parts communicate
- Services must be client informed and emphasize educated clients
- System must be set up so reimbursement rates are fair
- System must be simple and easy to navigate

Provider Perspective – Exercise 1

What's needed to increase # with high quality of life/health

- Simplification of implementation and administration of services
- Access to preventative care
- Adequate reimbursement to providers of services
- Adequate provider reimbursement in amount and timing
- Inclusion of substance abuse disorders
- Integrated care
- Removing obstacles so the system functions more like a single payer plan without having to go to hoops to get service
- Full range of services so people can get everything they need including behavioral and drug abuse treatment
- Access – being able to bring services to the client and to a wide range of services with no silos

Program User Perspective – Exercise 2

In a care management program, what must happen in order to create **knowledgeable and informed** recipients?

- Materials and resources should be easy for consumers and caregivers to understand
- Multiple modes to get info to caregivers and user (NOT JUST ELECTRONIC)
- Family involvement should be encouraged

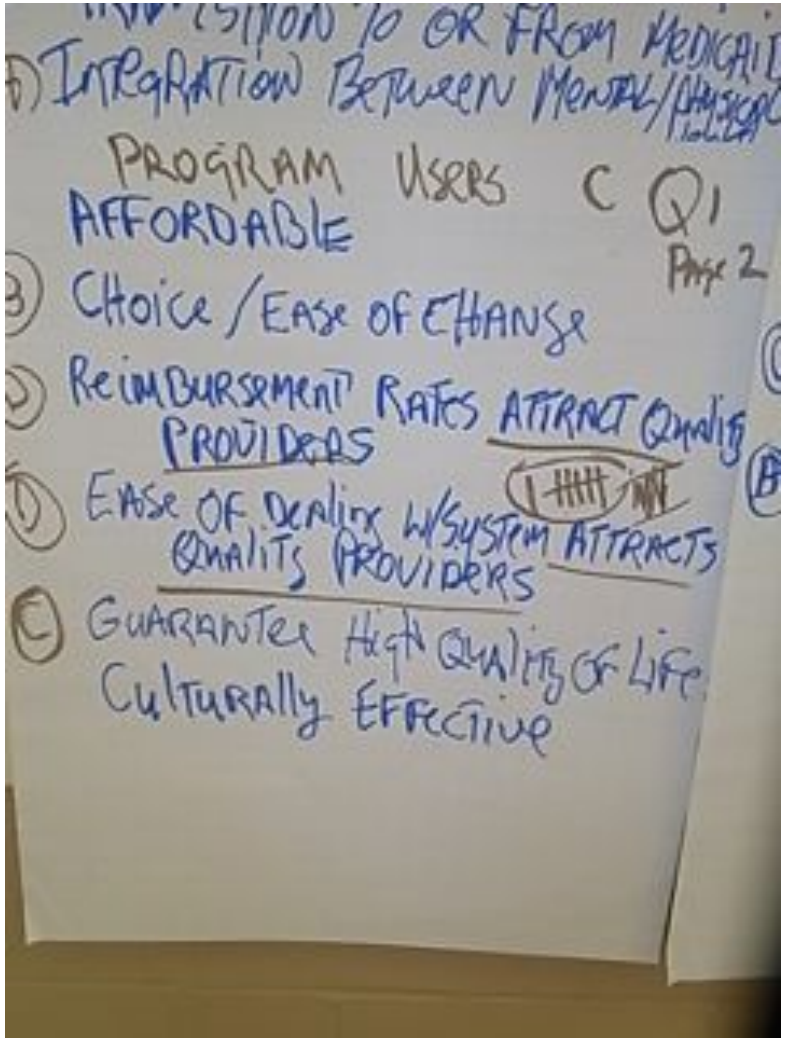
Provider Perspective – Exercise 2

In a care management program, what must happen in order to **create satisfied providers** instead of dissatisfied (or **Resistant**) providers?

- Providers need to be adequately reimbursed
- Services need to be available locally
- Ongoing input and evaluation with provider partners to explore system design oversight and resistance
- Need happy, satisfied customers.
- Adequate reimbursement – for ALL SERVICES from behavioral health, to hospice, to substance abuse, etc
- Provider incentives to provide comprehensive care – with time and flexibility to provide care.
- Need to treat whole person in an integrated way
- Uncomplicated system with reduced administrative burden – fewer hoops and less time required away from clients.
- Adequate reimbursement.
- Acknowledgement of coordination and case management as being a service
- Individual care that people need
- A system that assumes positive intent of providers and values and respects them.

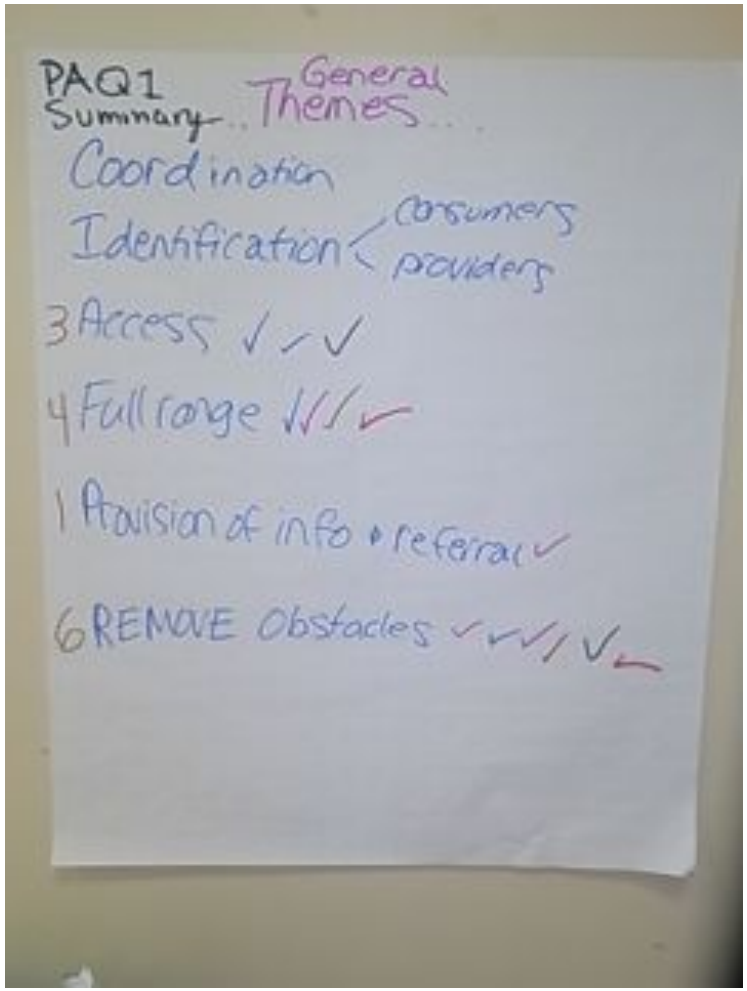
Program User Perspective - Exercise 1

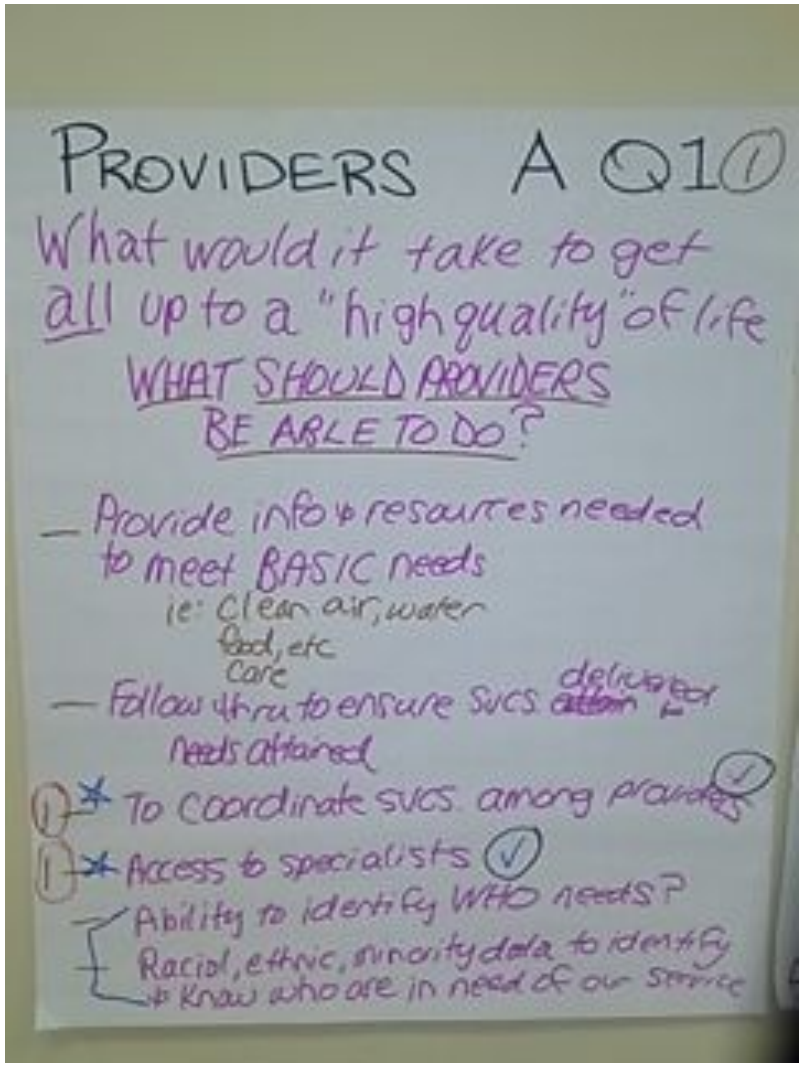
What's needed to increase # with high quality of life/health?

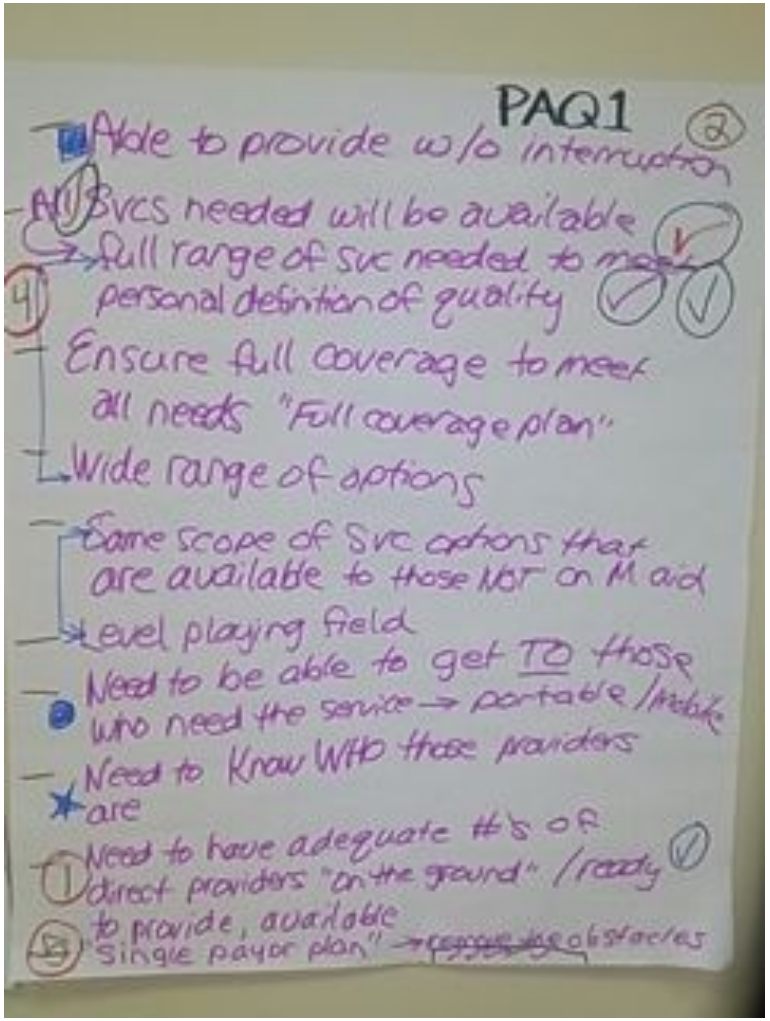


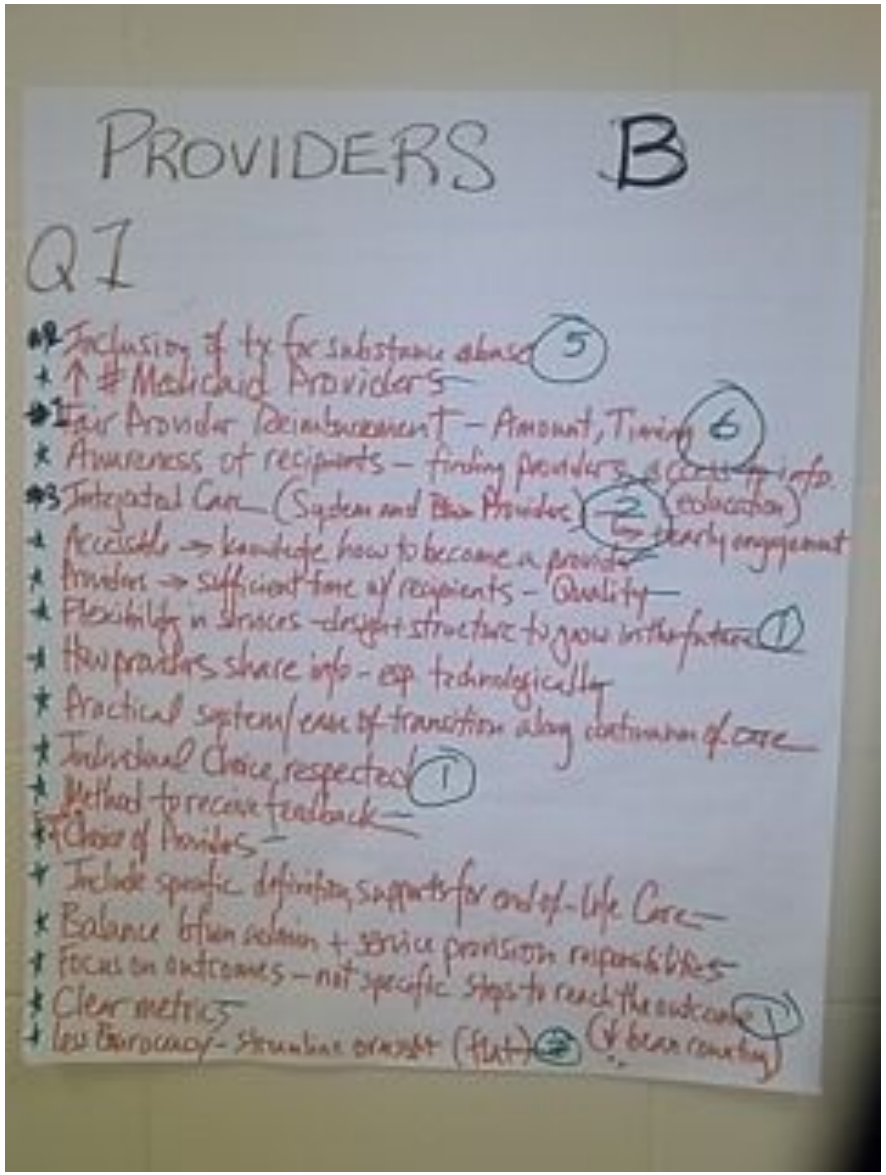
Provider Perspective – Exercise 1

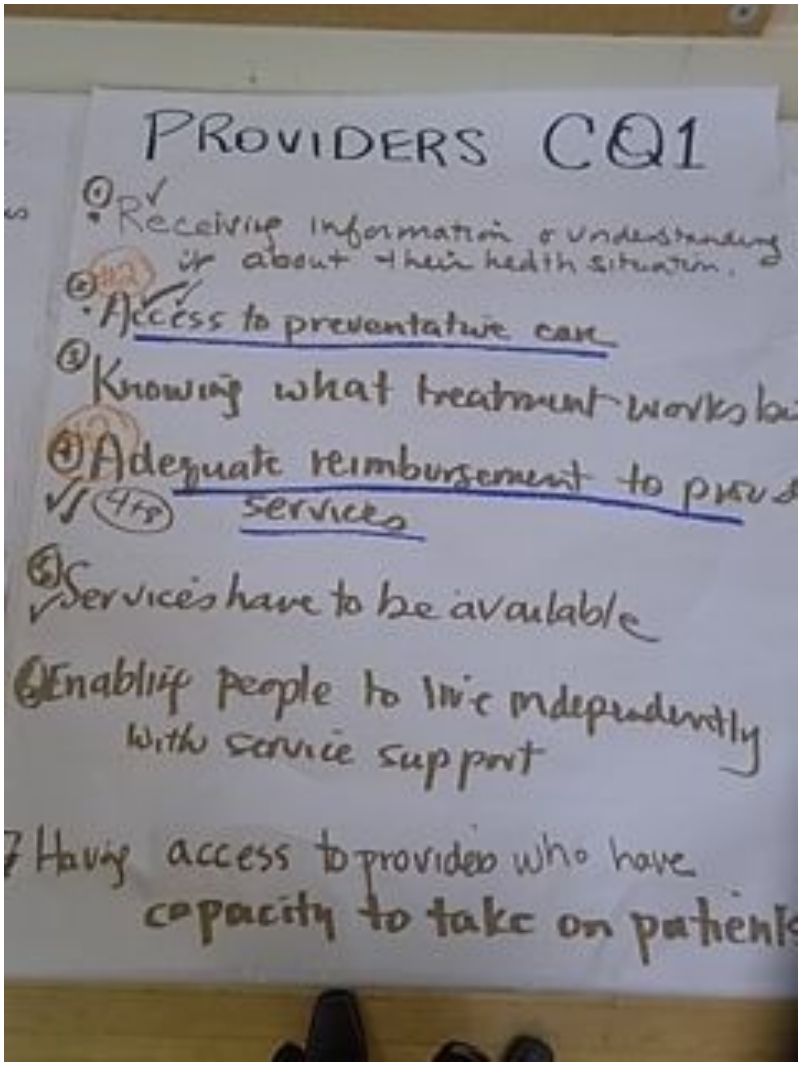
What's needed to increase # with high quality of life/health

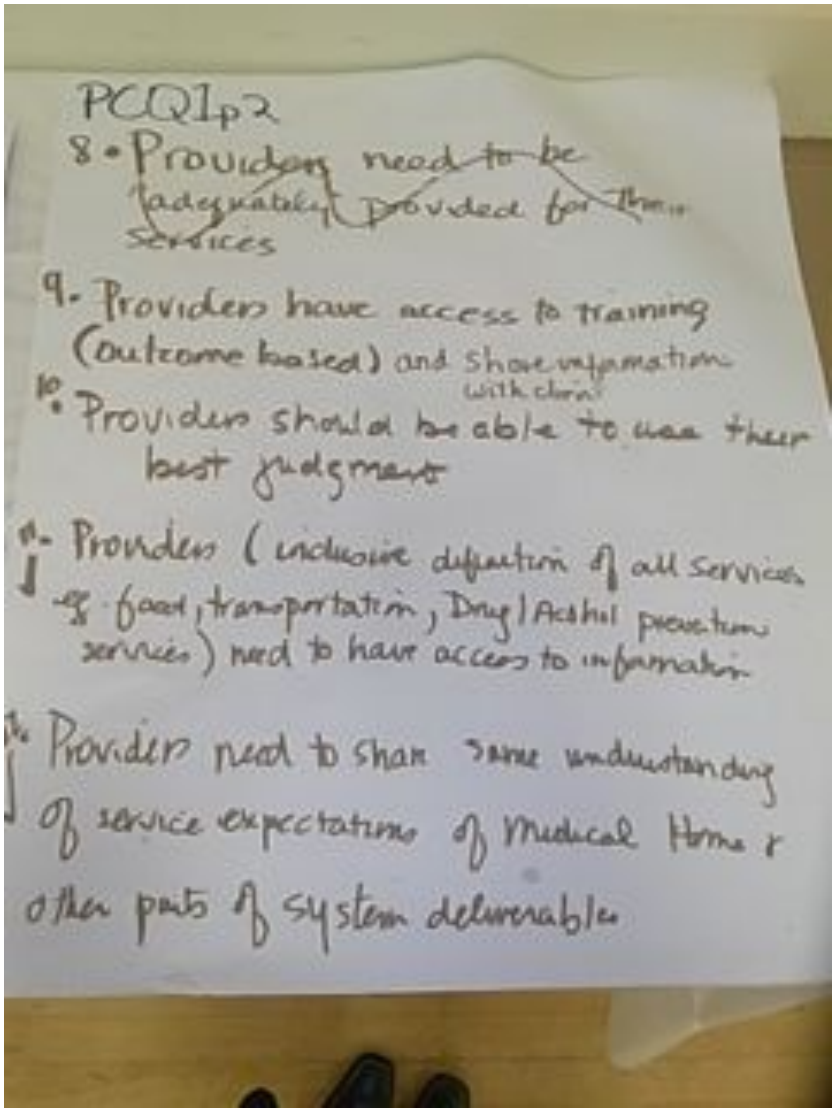


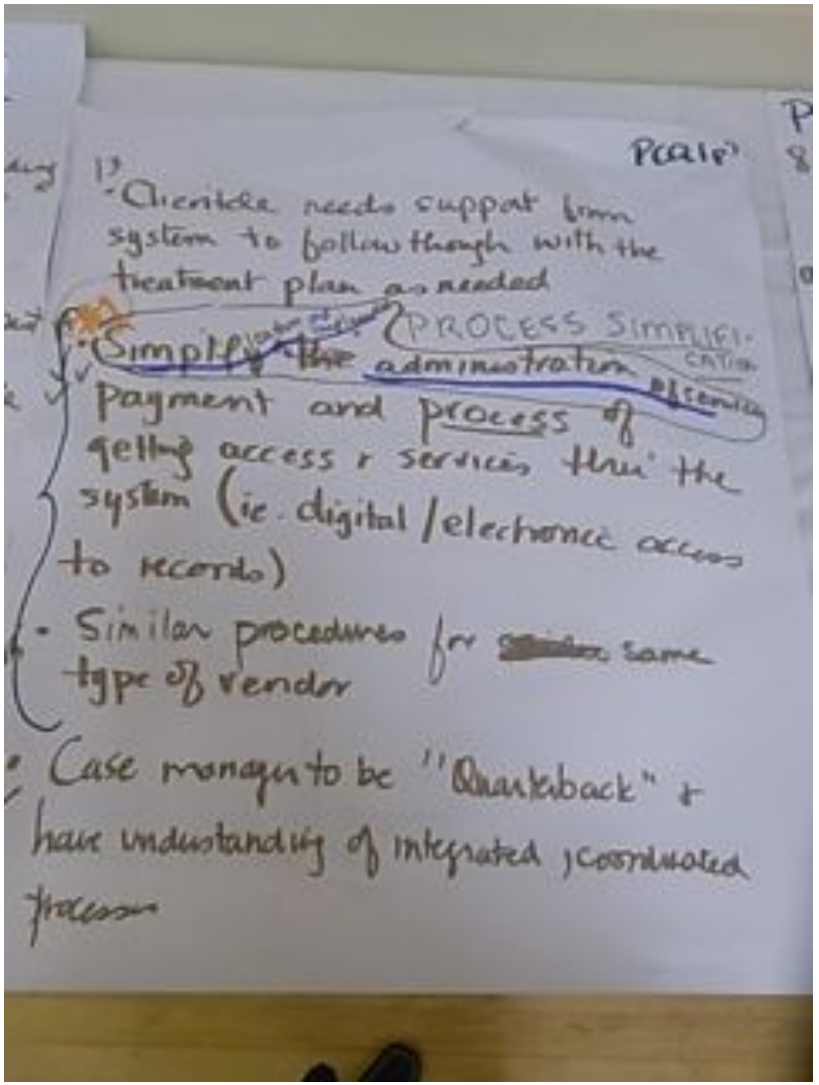

PROVIDERS A Q1
What would it take to get all up to a "high quality" of life
WHAT SHOULD PROVIDERS BE ABLE TO DO?
- Provide info & resources needed to meet BASIC needs
ie: Clean air, water
food, etc
Care
- Follow thru to ensure SVCS delivered & needs attained
To coordinate SVCS among providers
Access to specialists
Ability to identify WHO needs?
Racial, ethnic, minority data to identify
Know who are in need of our service


PAQ1
Able to provide w/o interruption
All SVCS needed will be available
full range of svc needed to meet personal definition of quality
Ensure full coverage to meet all needs "Full coverage plan"
Wide range of options
Same scope of SVC options that are available to those NOT on M aid
Level playing field
Need to be able to get TO those who need the service → portable/mobile
Need to Know WHO those providers are
Need to have adequate #'s of direct providers "on the ground" / ready to provide, available
"Single payor plan" → [illegible] obstacles


PROVIDERS B
Q1
Inclusion of tx for substance abuse (5)
↑ # Medicaid Providers
Fair Provider Reimbursement – Amount, Timing (6)
Awareness of recipients – finding providers, accessing info.
Integrated Care (System and Plan Provider) (2) (education)
early engagement
Accessible → knowledge how to become a provider
Providers → sufficient time w/ recipients – Quality
Flexibility in services – design structure to grow in the future (1)
How providers share info – esp technologically
Practical system/ease of transition along continuum of care
Individual Choice respected (1)
Method to receive feedback
Choice of Providers
Include specific definitions, supports for end-of-life Care
Balance between decision + service provision responsibilities
Focus on outcomes – not specific steps to reach the outcome (1)
Clear metrics
Less Bureaucracy – Streamline oversight (flat)

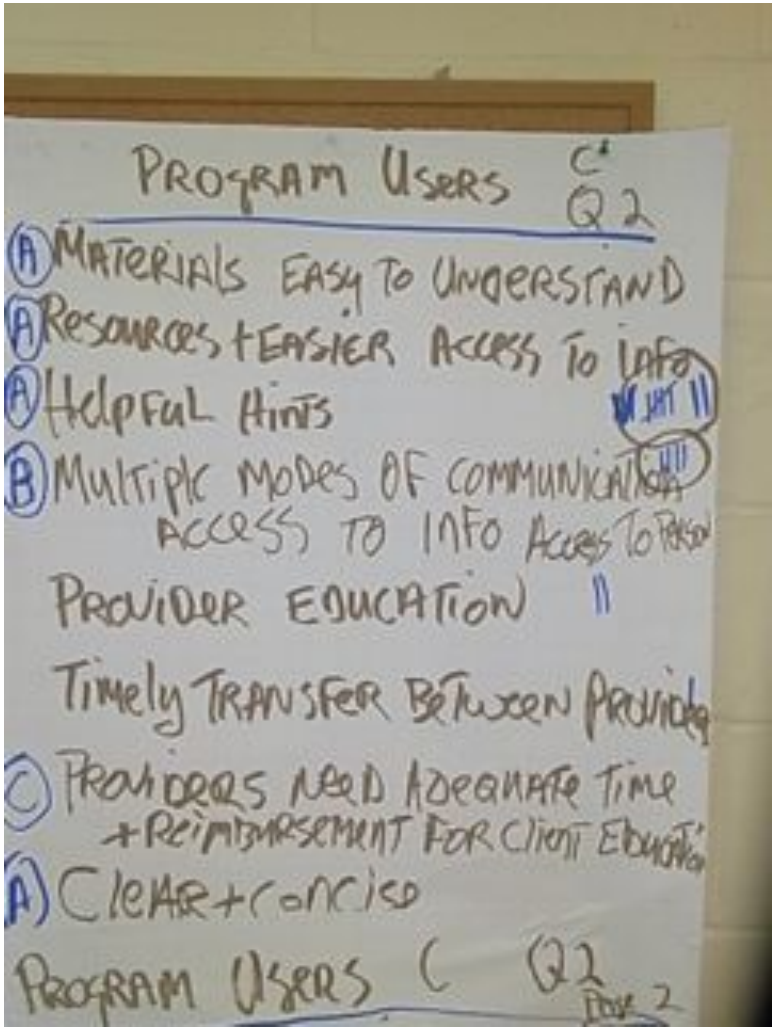

PROVIDERS CQ1
① Receiving information & understanding it about their health situation.
② Access to preventative care
③ Knowing what treatment works
④ Adequate reimbursement to provide services (4fs)
⑤ Services have to be available
⑥ Enabling people to live independently with service support
7 Having access to providers who have capacity to take on patients

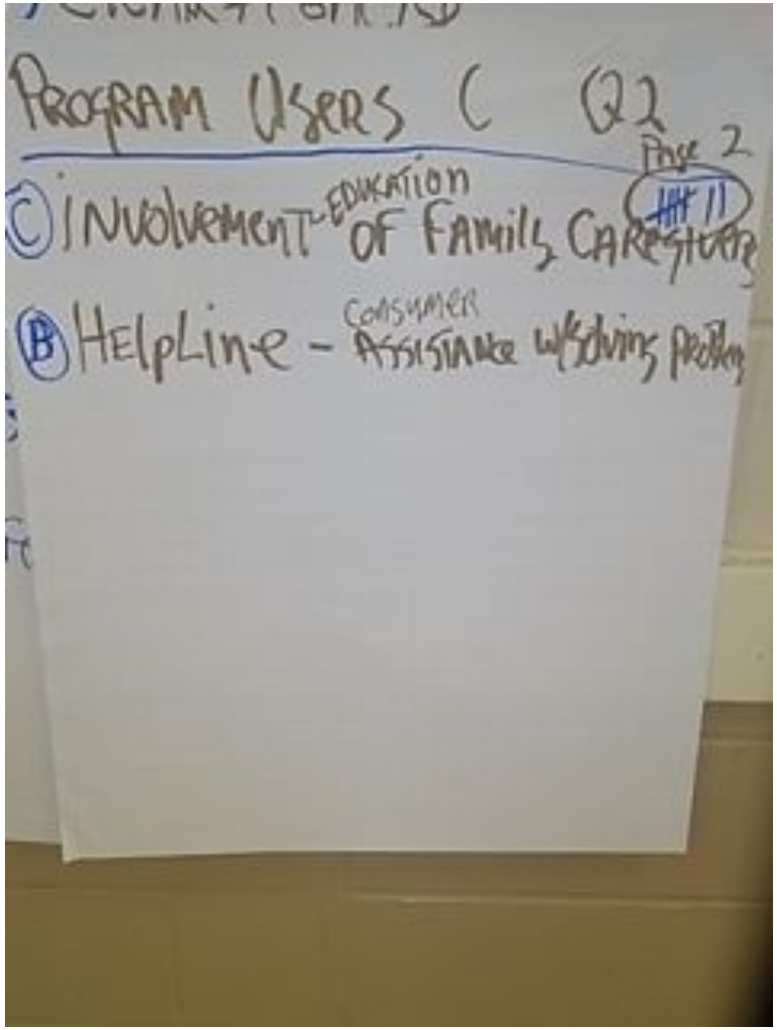

PCQ1p2
8. Providers need to be adequately provided for the services
9. Providers have access to training (outcome based) and share information with clients
10. Providers should be able to use their best judgment
11. Provider (inclusive definition of all services - food, transportation, Drug/Alcohol prevention services) need to have access to information
12. Provider need to share same understanding of service expectations of Medical Home & other parts of system deliverable


PCQ1p1
13. Clientele needs support from system to follow through with the treatment plan as needed
PROCESS SIMPLIFICATION
Simplify the administration efficiency payment and process of getting access & services thru the system (ie. digital/electronic access to records)
Similar procedures for same type of vendor
Case manager to be "Quarterback" & have understanding of integrated, coordinated process

Program User Perspective – Exercise 2

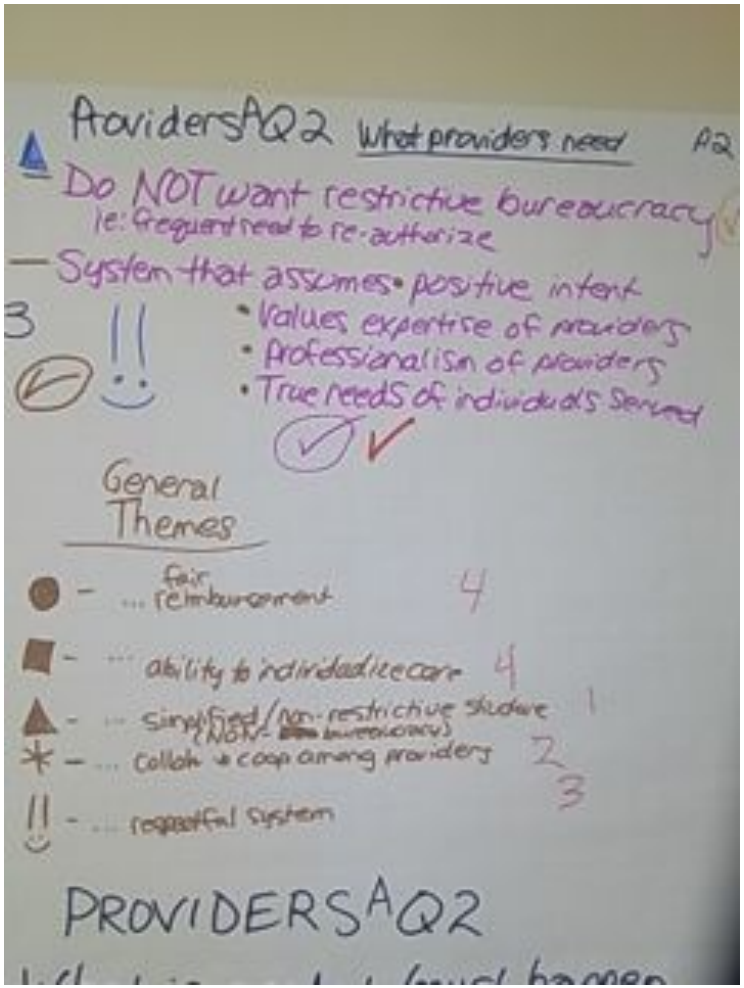
In a care management program, what must happen in order to create **knowledgeable and informed** recipients?

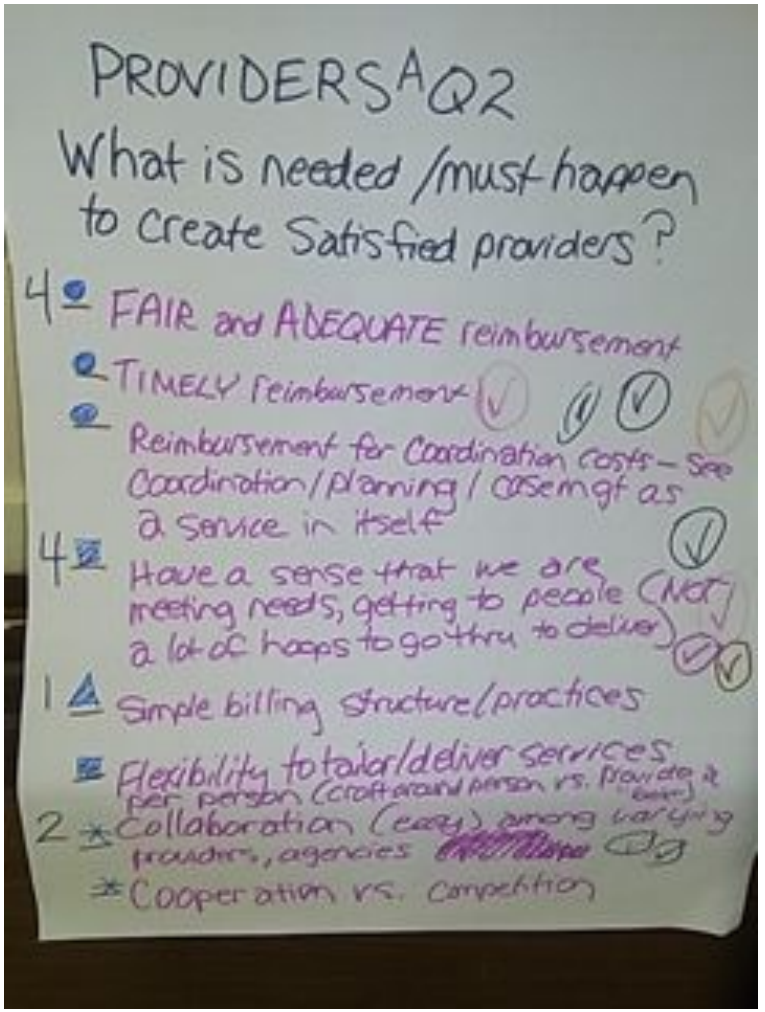


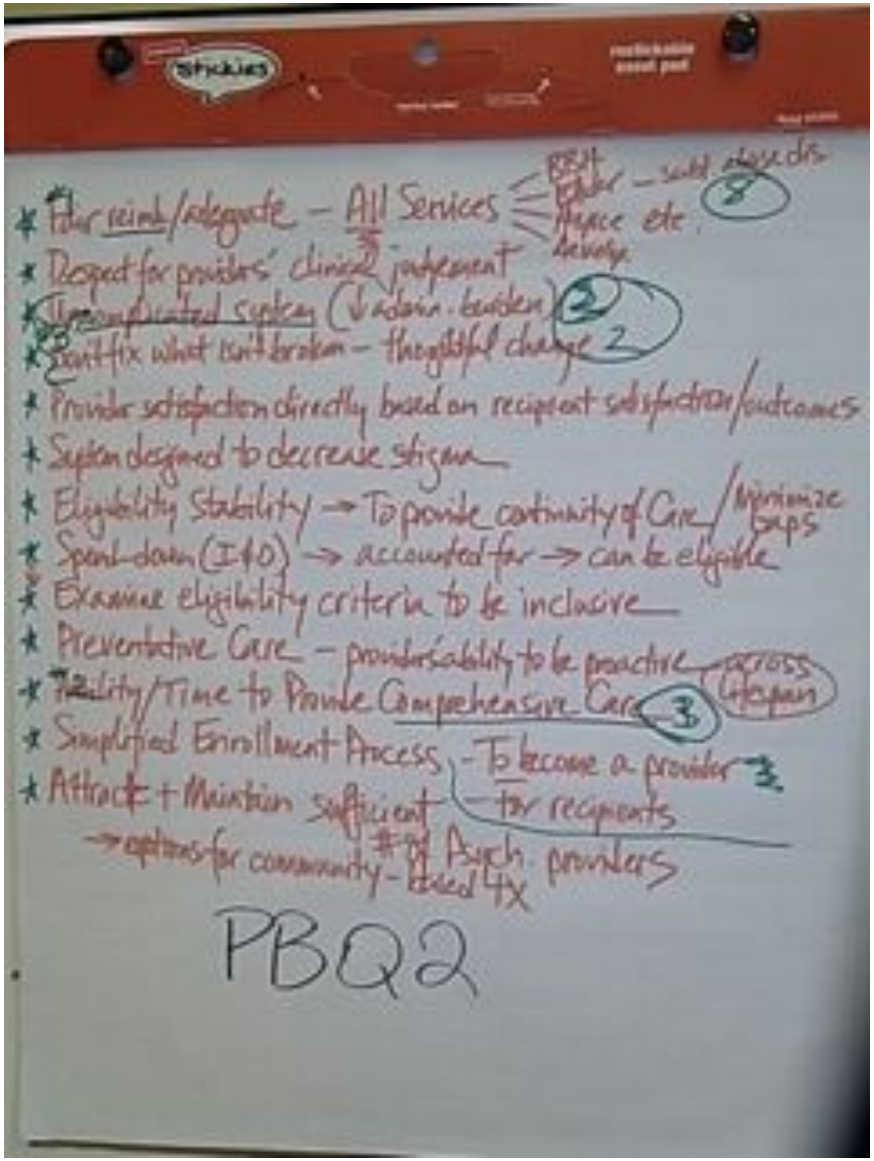


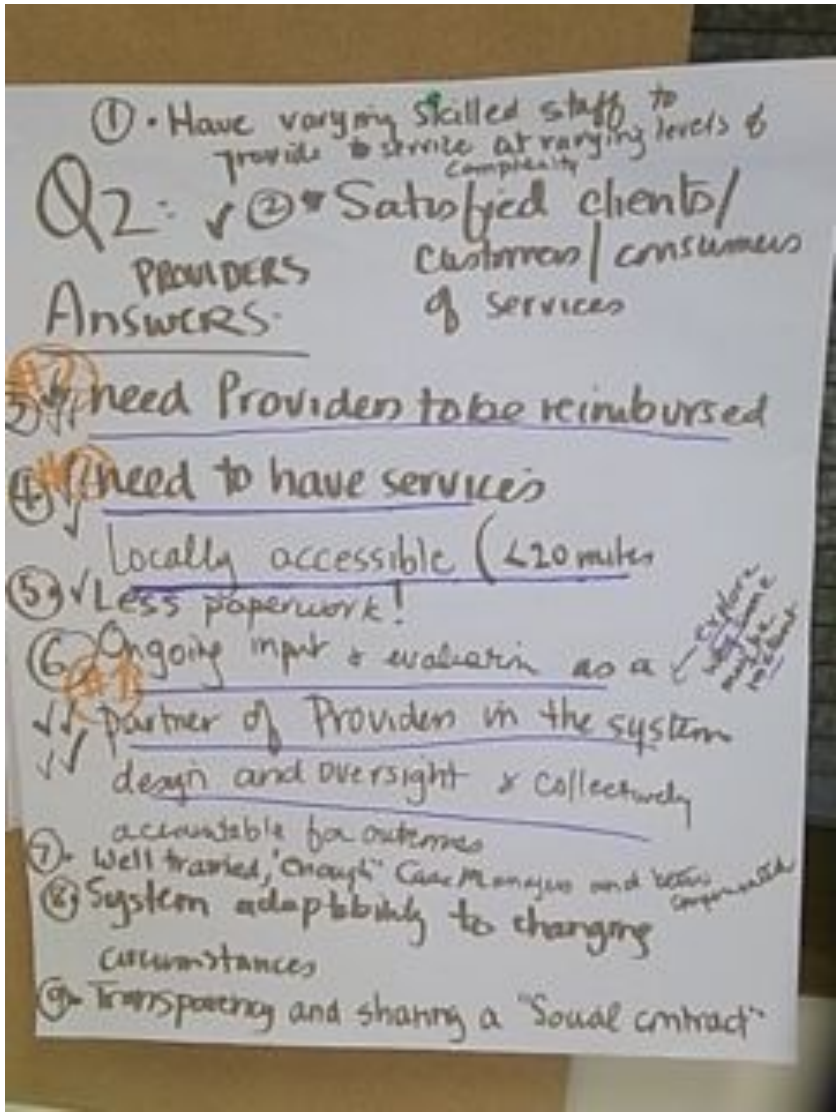
Provider Perspective – Exercise 2

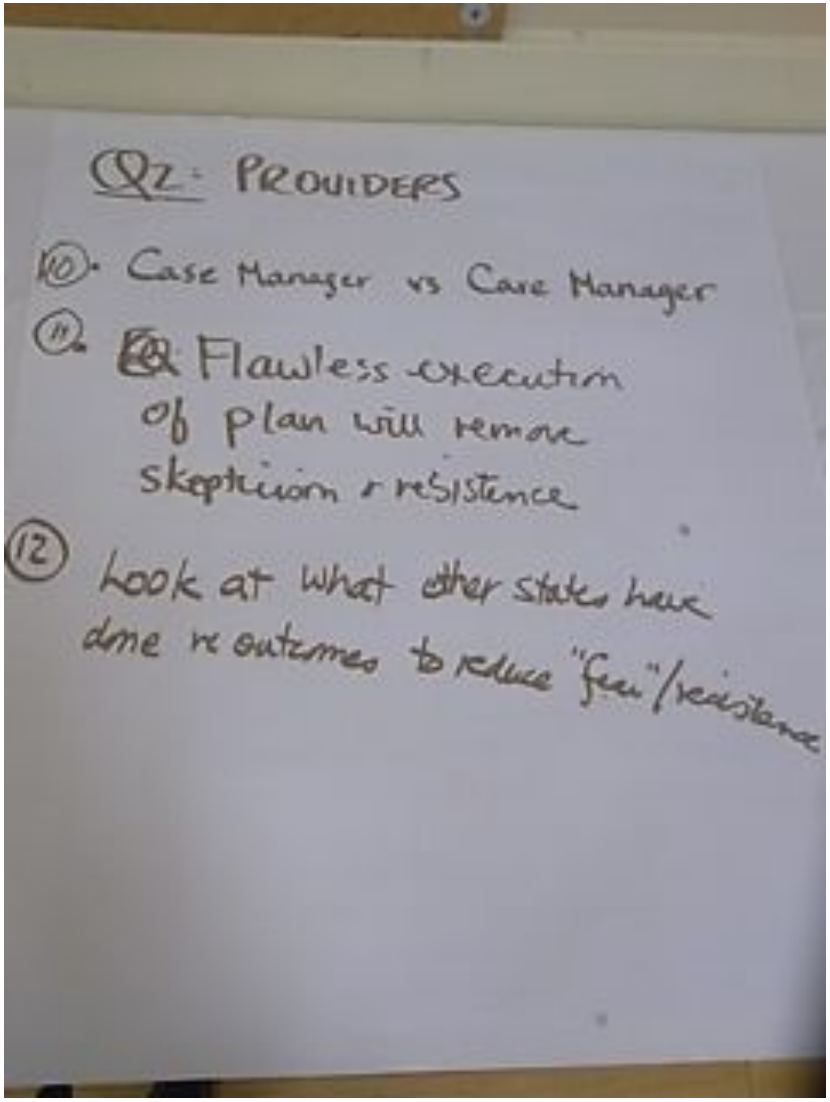
In a care management program, what must happen in order to **create satisfied providers** instead of dissatisfied (or **Resistant**) providers?






Stickies
PBQ2


① • Have varying skilled staff to provide a service at varying levels of complexity
Q2: ✓ ② Satisfied clients/ customers/ consumers of services
PROVIDERS
Answers:
need Providers to be reimbursed
need to have services
locally accessible (<20 miles
✓ Less paperwork!
Ongoing input & evaluation as a partner of Providers in the system design and oversight & collectively accountable for outcomes
Well trained, "enough" Case Managers and Care Coordinators
System adaptability to changing circumstances
Transparency and sharing a "Social contract"


Q2: PROVIDERS
⑩ • Case Manager vs Care Manager
⑪ Flawless execution of plan will remove skepticism & resistence
⑫ Look at what other states have done re outcomes to reduce "fear"/resistance